

We took the VBAC summary by rules or statutes 2011 and compiled as much information for each state that we could find. This allows committee members to review rules and guidelines of other states that allow VBAC out of the hospital.

## Tennessee

<http://health.state.tn.us/Downloads/g5062255.pdf>

### PHYSICIAN CONSULTATION AND REFERRAL

The Midwife shall consult with a physician whenever there are significant deviations (including abnormal

laboratory results, during a client's pregnancy and birth, and/or with the newborn. If a referral to a physician is

needed, the Midwife will remain in consultation with the physician until resolution of the concern.

It is

appropriate for the Midwife to maintain care of her client to the greatest degree possible, in accordance with the

client's wishes, remaining present through the birth, if possible.

The following conditions require physician consultation and may require physician referral and/or transfer of

care.

1. Pre-existing Conditions include but are not limited to:

a. cardiac disease;

b. active tuberculosis;

c. asthma, if severe or uncontrolled by medication;

d. renal disease;

e. hepatic disorders;

f. endocrine disorders;

g. significant hematological disorders;

h. neurologic disorders;

i. essential hypertension;

j. active cancer;

k. diabetes mellitus;

l. history of newborn with positive Group Beta Strep (GBS);

m. previous Cesarean section with classical incision;

n. three or more previous Cesarean sections;

o. previous Cesarean section within one year of current EDD;

p. current alcoholism or abuse;

q. current drug addiction or abuse;

r. current severe psychiatric illness;

s. isoimmunization;

a. positive for HIV antibody.

NH- New Hampshire Midwifery Regulations ~ Care for Post Cesarean Pregnancies by  
Community-based Midwives

[http://www.collegeofmidwives.org/collegeofmidwives.org/Standards\\_2004/New%20Hampshire%20VBAC%20rules%202003..pdf](http://www.collegeofmidwives.org/collegeofmidwives.org/Standards_2004/New%20Hampshire%20VBAC%20rules%202003..pdf)

## New Mexico

[http://www.health.state.nm.us/PHD/midwife/NMMA%202008%20practice%20guidelines.p  
df](http://www.health.state.nm.us/PHD/midwife/NMMA%202008%20practice%20guidelines.pdf)

### VAGINAL BIRTH AFTER CESAREAN INFORMATION AND CARE SCHEDULE PHILOSOPHY

The New Mexico Midwives Association believes women desiring vaginal birth after cesarean (VBAC) should have the opportunity to deliver out of the hospital after carefully considering the risks and benefits.

#### I Eligibility for Out-of-Hospital VBAC

- A. History of only one previous cesarean at least eighteen months prior to the EDD of the current pregnancy, or last birth was a successful VBAC
- B. Records documenting low transverse uterine incision without extension, or proof of subsequent VBAC
- C. Placental location documented by ultrasound to be not previa nor low and anterior
- D. Birth location provides for a transport time no longer than 30 minutes from problem recognition to arrival at hospital with surgical and pediatric services

#### II Antepartum Care

- A. Review history and records of previous cesarean birth
- B. Document previous or subsequent vaginal deliveries
- C. Record discussion of risks vs. benefits of trial of labor and possible alternatives
- D. Document provision of relevant information and/or education for the special concerns of VBAC mothers and families; refer to appropriate support groups where available
- E. Provide for third trimester ultrasound for documentation of placental location unless previously documented
- F. Discuss the potential of an antepartum uterine rupture which can also occur, often late in the third trimester, although less frequently than in labor
- G. Explain and discuss “The New Mexico Midwives Association Informed Consent for Out-Of-Hospital VBAC” and obtain appropriate signatures
- H. Perform assessment and prenatal work-up as provided for all mothers

#### III Intrapartum Care

- A. Mothers in labor will be monitored as described under Labor and Birth Care Schedule
  - B. If mother has never delivered vaginally, assess progress by nulliparous criteria
  - C. If mother has delivered vaginally, assess progress by multiparous criteria
  - D. Consider placement of a saline lock upon confirming active labor
- Practice Guidelines for NM Midwives – June 2008 94
- E. Continually assess for symptoms of uterine rupture.

1. The most common, and sometimes only, sign of uterine rupture is

New Mexico Continued

a non-reassuring fetal heart rate pattern

2. FHT decelerations or abnormal pattern

3. Sudden, severe, tearing; unusual pain

4. Frank, bright red bleeding

5. Loss of uterine contractions or tonus

6. Signs or symptoms of shock

7. Uncontrolled postpartum bleeding

IV Indications for transfer to hospital

A. Mother's request

B. Signs/symptoms of uterine rupture

C. Any other usual indications for transfer

V Risks of Pregnancy and Birth After Cesarean Section

A. Uterine Rupture: In some instances, the uterus may rupture, or tear open, at the site of the scar, which may cause neurological injury or death to the baby, cause maternal hemorrhage, or death to the mother. The risk of uterine rupture in spontaneous labor with a single low transverse uterine scar is 0.4 to 0.8% (1,2). The risk is three times higher when the birth interval is 18 months or less (3). Vaginal births after two or more cesareans have a three-to-four fold increase - 1.7 to 3% - (1) in uterine rupture over those who have had only one previous cesarean. The risk of uterine rupture when the last birth was a successful VBAC is 0.2% (1, 2).

B. Placenta Problems: Pregnancies after a cesarean birth have an increased risk of the placenta being implanted over the uterine scar, accreta, increta or percreta. This can lead to serious problems with placental delivery, including hemorrhage and significant risk of maternal death. An ultrasound performed in the third trimester of pregnancy can determine placental location, but may not be foolproof in predicting all placental problems.

VI Risks of Hospital Options

A. Hospital VBAC These medical procedures, at times used during hospital births, have been shown to increase the risk of uterine rupture:

1. Pitocin induction or augmentation

2. Use of Misoprostil or Prostaglandins

3. Epidural anesthesia

B. Elective Repeat Cesarean Section

The risks of an emergency cesarean for an unsuccessful VBAC are higher than the risks of a planned cesarean delivery. However, surgical deliveries carry the following risks as compared to vaginal births:

1. Higher maternal mortality rate

2. Higher risk of maternal infection

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3. Increased risk of anesthesia complications

4. Increased risk of respiratory distress for the infant

VII Informed Consent for Out-Of-Hospital VBAC

In order to undertake an out-of-hospital VBAC, the mother must sign the New Mexico Midwives Association Informed Consent for Out-Of-Hospital VBAC, stating that she agrees to and fully takes responsibility for the risks.

NEW MEXICO MIDWIVES ASSOCIATION  
INFORMED CONSENT FOR OUT-OF-HOSPITAL  
VAGINAL BIRTH AFTER CESAREAN (VBAC)

Client is to initial each paragraph

I have been told the risks of having a vaginal birth after a cesarean birth (VBAC), for both me and my baby. I understand the special risk is that my uterus could tear open in labor. (The medical word for this is “uterine rupture”) The risk of my uterus tearing open is greater for me than it is for a woman who has never had a cesarean birth. This is because the place where my uterus was cut open could tear open again.

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I understand that my uterus could tear open whether I have my baby in a hospital, at home, or in a birth center.

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If my uterus tears open, my baby could have brain damage for the rest of his or her life, or I could bleed very heavily, or both could happen. My baby could die, I could die, or both of us could die.

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If my uterus tears open, I will need to have a cesarean to deliver my baby and stop the bleeding. For the least damage to my baby and/or me, the cesarean needs to be done quickly. If I am having my baby at home or in a birth center, the time it takes to travel to the hospital for a cesarean may cause more damage than if I were having my baby at a hospital and able to have an immediate cesarean.

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I might need a cesarean for other reasons, even if my uterus does not tear open. If I do have a cesarean I am more likely to have problems like infection and heavy bleeding than if I had planned a scheduled repeat cesarean birth.

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I understand that I could choose to have a planned repeat cesarean instead of a planned VBAC. I have been told the risks of VBAC and of having a repeat cesarean birth.

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If my midwife decides at any time that my baby or I need to go to a hospital, I will go to the hospital even if I disagree. Also, I understand that if I decide to go to a hospital at any time, my midwife will go with me to the hospital even if she does not think I need to go.

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Practice Guidelines for NM Midwives – June 2008

I have read the New Mexico Midwives Association “Vaginal Birth After Cesarean Information and Care Schedule”, and discussed it with my midwife. \_\_\_\_\_

I have read, and I understand, the above information, as well as the New Mexico Midwives Association “Vaginal Birth After Cesarean Information and Care Schedule”. All my questions about VBAC have been answered and I understand the answers.

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I confirm that:

I have had only one cesarean birth; \_\_\_\_\_  
or that I have had at least one vaginal birth since I had a cesarean birth. \_\_\_\_\_

(Initial the one that applies to you, or both if they are both true.)

My medical records say the cut was made across the lower part of my uterus. I understand that the cut in my uterus may have been made in a different place or direction from the cut in my skin. \_\_\_\_\_

There will be at least 18 months from the date of my cesarean to the due date of this pregnancy. \_\_\_\_\_

I will have an ultrasound in the last three months of my pregnancy to find out if the placenta is in a dangerous position. \_\_\_\_\_

I will have my birth within a 30 minute distance from a hospital where a cesarean could be done, and pediatric care could be provided to my baby. \_\_\_\_\_

I understand all of the special risks of a VBAC birth and the risks of having a VBAC at home or at a birth center, and I choose to plan a home or birth center VBAC birth.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Midwife \_\_\_\_\_

Colorado pg 14

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22Colorado+Midwives+Registration+Rules+and+Regulations%2C+effective+July+1%2C+2007.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251832218824&ssbinary=true>

**RULE 12 – STANDARDS FOR VAGINAL BIRTH AFTER CESAREAN SECTION**

**(VBAC)** The purpose of this rule is to establish parameters for VBAC clients seeking midwifery care during pregnancy in order to safeguard the client’s welfare pursuant to Section 12-37-105(11), C.R.S. A. A direct-entry midwife shall not assume primary responsibility for prenatal care and birth attendance for women who have had a previous cesarean section unless all of the following conditions are met: 1. All prospective VBAC women shall sign an informed consent statement, which shall be retained in the client’s records and include the following: (a) VBAC educational information including history of VBAC and client’s own personal information; (b) Associated risks and benefits of VBAC at home; (c) A workable hospital transport plan; (d) Alternatives to VBAC at home; and (e) Other information as required by the Director. 2. A workable hospital transport plan must be established for home VBAC. The plan shall be in writing and include: (a) Place of birth within 30 minutes of transport to the nearest hospital or emergency medical center able to perform an emergency cesarean; (b) Readily available emergency numbers for the nearest hospital or emergency medical center; and (c) Provision for phone contact with the nearest hospital or emergency medical center prior to any transport notifying the destination that transport is in progress. 3. There has been at least 18 months from the client’s cesarean delivery to the due date of the current pregnancy.<sup>15</sup>

4. The client with 2 or more cesarean deliveries has also had a vaginal delivery since the last cesarean delivery. B. The direct-entry midwife shall obtain prior client cesarean written records, shall analyze the indication for the previous cesarean, and retain the records along with a written assessment of the physical and emotional considerations in the

client's files. If the direct-entry midwife is unable to obtain the written records, the direct-entry midwife shall not retain the woman as a client. C. Records that show a previous classical uterine/vertical incision or any previous uterine surgery which required an incision into the uterine fundus are a contraindication to VBAC at home and shall require immediate transfer of care of the client. D. Direct-entry midwife shall not induce or augment labor by the use of chemicals or herbal supplements or nipple stimulation. E. A direct-entry midwife shall be present and manage the VBAC delivery from the onset of active labor throughout the immediate postpartum period.

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<http://adminrules.idaho.gov/rules/current/24/2601.pdf>

**04. Conditions for Which a Licensed Midwife Must Recommend Physician Involvement.**

Before providing care for a client with a history of any of the disorders, diagnoses, conditions or symptoms listed in this **IDAHO ADMINISTRATIVE CODE IDAPA 24.26.01 Bureau of Occupational Licenses Rules of the Idaho Board of Midwifery Section 356 Page 13** Subsection 356.04, a licensed midwife must provide written notice to the client that the client is advised to see a physician licensed under Chapter 18, Title 54, Idaho Code, during the client's pregnancy. Additionally, the licensed midwife must obtain the client's signed acknowledgement that the client has received the written notice. The disorders, diagnoses, conditions, and symptoms are: (3-29-10) **a.** Previous complicated pregnancy; (3-29-10) **b. Previous cesarean section;** (3-29-10) **c.** Previous pregnancy loss in second or third trimester; (3-29-10) **d.** Previous spontaneous premature labor; (3-29-10) **e.** Previous pre-term rupture of membranes; (3-29-10) **f.** Previous pre-eclampsia; (3-29-10) **g.** Previous hypertensive disease of pregnancy; (3-29-10) **h.** Parvo; (3-29-10) **i.** Toxo; (3-29-10) **j.** CMV; (3-29-10) **k.** HSV; (3-29-10) **l.** Previous maternal/newborn group b streptococcus infection; (3-29-10) **m.** A body mass index of at least thirty-five (35.0) but less than forty (40.0) at the time of conception; (3-29-10) **n.** Underlying family genetic disorders with potential for transmission; or (3-29-10) **o.** Psychosocial situations that may complicate pregnancy. (3-29-10)

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[http://vtprofessionals.org/opr1/midwives/rules/LMW\\_Rules.pdf](http://vtprofessionals.org/opr1/midwives/rules/LMW_Rules.pdf)

**PREVIOUS CESAREAN DELIVERY**

The following requirements must be met for vaginal birth after cesarean (VBAC). In addition, prenatal consultation is advised when available.

- (1) The midwife must consult with a licensed M.D. or D.O. to ascertain that the client had only one documented previous lower uterine segment cesarean section with uterine closure of more than one layer.
- (2) There must be at least 18 months from the client's cesarean to the due date of the current pregnancy.
- (3) The client must obtain ultrasound documentation to determine that the location of the placenta is not previa or is not low and anterior.
- (4) Signed informed consent must be present in the client's chart. See Appendix A.

(5) The midwife must perform fetal auscultation at least every 15 minutes during active labor and more frequently if necessary and at least every five minutes during the second stage of labor and more frequently if necessary.

(6) The birth site must be located within 30 minutes= transport time from a hospital emergency room.

(7) Two licensed midwives must be present during the birth.

(8) No labor induction or augmentation of any kind must be done, including use of any chemical or herbal medication or nipple stimulation.

(9) Pre-admission forms must be completed for the client before labor, for the hospital to which the client may possibly be transferred.

(10) Prenatal records for the client must be sent before labor to the back-up system for the birth (hospital, labor and delivery unit, or physician practice).

No later than one year from the effective date of these rules or earlier upon written request, the Director, in consultation with the advisor appointees and the Commissioner of Health, will review current scientific research on vaginal birth after cesarean (VBAC), for the purpose of seeking amendment of this rule to reflect current scientific research findings, provided the Director concludes after consultation that amendment is necessary.