VBAC summary by rules or statutes
2011

Of the 26 states with licensure or statutory authority for the legal practice of CPMs, 22 allow licensed midwives to attend VBAC at home, but three of those have impractical requirements, thus 19 actually permit VBACs. A description of each state is listed below, including the date of initial licensure.

►Only FOUR states do not allow VBAC by licensed midwives at home:
Alaska (1999), **Arizona** (1977), **Arkansas** (1983), **and South Carolina** (1976/2004)

►**MISSOURI** (2007) and **MAINE** (2008) have established statutory authority for legal practice for CPMs without regulation or licensure, so there are no rules regarding attendance at VBACs.

►States with licensure but no restrictions or regulations affecting the option of VBAC at home with a licensed midwife are: **CALIFORNIA** (1993), **MINNESOTA** (1999), **VIRGINIA** (2005), **WASHINGTON** (1981)

►States where the only restriction is the evidence of a previous low transverse incision are: **OREGON** (1993, voluntary licensure, recommends documentation of previous incision, **TEXAS** (1999), **TENNESSEE** (2003), statute does not restrict but requires following protocols of TN Midwives Association, which recommends documentation of transverse incision).

►States which allow VBAC if specific conditions are met other than a previous low transverse incision:

COLORADO (1993) VBAC allowed if within 30 minutes of a facility able to perform a cesarean.

FLORIDA (1992) For a primary VBAC, the midwife must consult with a physician who agrees that the mother can expect a normal pregnancy and delivery. Physicians have been cooperative, and many LMs are attending VBACs at home. Secondary VBACs need no consultation.

IDAHO (2009) Rules prohibit a licensed midwife from attending women with a history of more than one prior cesarean section, a cesarean section within 18 months of the current delivery, or any cesarean section that was surgically closed with a classical or vertical uterine incision, also requires the midwife to recommend that the client see if physician if she has had a previous C/S. Requires transfer to a physician if a VBAC mother has a second stage of more than two hours.

MONTANA (1991) Must attempt to consult and/or transfer care to a physician. If no physician will consult, can consult with another midwife for review of risk factors. Allows VBAC with informed consent, written transport plan, and 18 months between pregnancies. Birth must be within 30 minutes of a hospital, and midwife must phone the hospital at initiation of labor, prior to transport, and after birth if no transport. Must also obtain written records of previous cesarean and must document transverse incision. Midwives are attending VBACs and are able to find cooperative physicians for the consultations.

NEW HAMPSHIRE (2000) Allows VBAC at home with a Licensed Midwife only if these conditions are met: Only one previous C/S; confirmed low transverse incision, no other uterine surgeries, at least 18 months between previous C/S and current due date; confirmed placenta is not low-lying; location no more than 20 minutes drive from a hospital with obstetrical and anesthesia services on call 24 hours a day. Must have a consultation with a physician affiliated with the closest hospital, consultation must include info on risks of HBAC; if can document refusal for this visit by every ob within range, the midwife may provide the information. Labor management: must take heart tones every 15 minutes during active labor and every five

minutes during second stage, monitor vaginal bleeding and/or abnormal abdominal pain. Must not indicate FTP by laboring more than two hours without cervical change, or one hour without progress of descent in second state or two hours with slow progress in second stage, or more than one hour without delivery of placenta. Must consult if there are repeated fetal heart rate abnormalities, unstable vital signs, significant bleeding or abnormal abdominal pain. Must use an extensive Informed Consent approved by the Midwifery Board.

NEW MEXICO (1978) Must document low transverse incision, only one previous cesarean, 18 months between previous C/S and current due date, ultrasound to determine placenta site, no more than 30 minutes required for transport time, Informed Consent

VERMONT (2001) Allows LMs to attend VBAC under these conditions: Physician consultation to determine documentation of lower uterine incision with double layer closure (if previous records available, consultation can be waived); only one previous C/S, at least 18 months from C/S to due date, ultrasound to determine placenta site; signed informed consent. Birth site must be within 30 minutes of a hospital with an ER; must file pre-admit forms with hospital and must file prenatal records prior to labor with either the back-up physician or the hospital. Labor management requires checking fetal heart rate every 15 minutes in active labor and every five minutes in second stage. Two licensed midwives must be present; no induction or labor stimulation of any kind (chemical, herbal, or nipple stimulation).

WISCONSIN (2006) Midwives must consult with a physician or CNM regarding VBAC clients. Consults may be by phone unless a visit is requested by the physician.CNM.

WYOMING (2010) Midwives may attend VBACs except for those with a history of more than one cesarean if there has been no intervening vaginal delivery, a cesarean within 18 months, or a vertical incision. Must also provide written advice to see a physician.

*__UTAH__, which did not have restrictions on VBACs when licensure began in 2005 and which had an 87% success rate for VBACs in 2008 with no bad outcomes, now restricts VBACs to women with no more than two previous cesareans. They now require documentation of transverse incision, ultrasound to determine placement of placenta, a special Informed Consent, and progress of at least one cm per 3 hours in active labor.

►States with regulatory authority for VBAC but where physician cooperation is required and unattainable are:

DELAWARE (2002) No prohibition in regulations, but licensure requires a collaborative agreement with a physician that includes practice guidelines and protocols; only one licensed CPM.

LOUISIANA (1985 Rules prohibit VBAC except when granted a specific waiver by the Midwifery Board following evidence that a physician has determined that vaginal delivery presents no untoward medical/obstetrical risk for the client. No midwives are able to get the required physician cooperation for VBAC so they are, in effect, not being done at home.

NEW JERSEY (2002) Requires co-management with a physician; also says birth must take place in a hospital; apparently limiting VBAC to CNMs with hospital privileges.

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