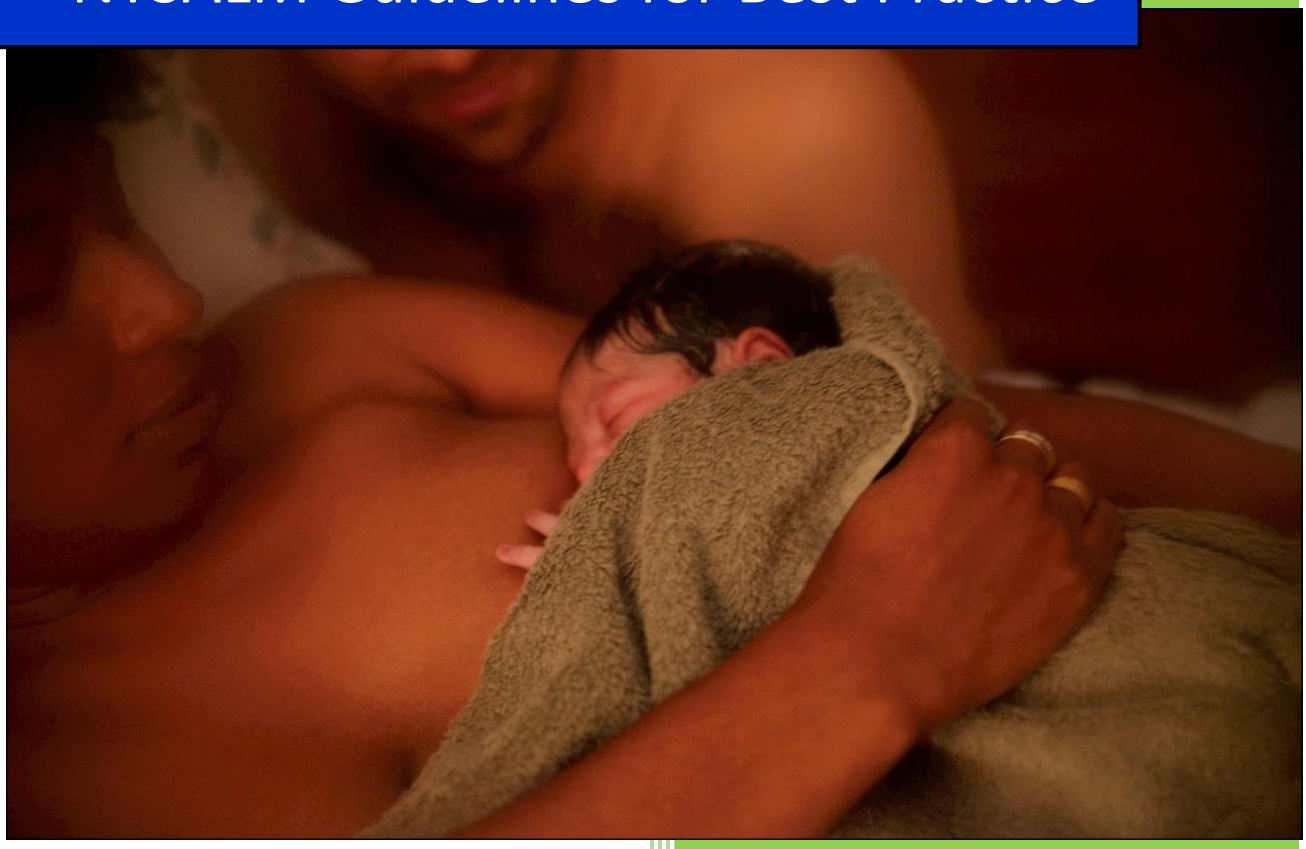
NEW YORK STATE ASSOCIATION OF LICENSED MIDWIVES

PLANNED HOME BIRTH IN NEW YORK STATE: NYSALM Guidelines for Best Practice



Home Birth Integration Initiative
NYSALM Quality Committee

Released for Trial October 2015
Updated December 2015
Finalized October 2017

nysalm.org

Contents

The NYSALM Home Birth Integration Initiative's commitment to quality, personally-satisfying, client-centered care includes using language respecting the personal gender identity of those who choose midwifery services.[1, 2] Consequently, we affirm language for this document that upholds both inclusivity and diversity. The criteria used for language choices in this document are drawn from the terms used by midwifery consumers to describe their personal identities. There are not single terms that meet the personal gender identity of each midwifery consumer. The majority of people giving birth identify as women, and some identify as trans men, gender non-conforming, gender fluid, queer, non-binary, and agender. The language chosen for this document summarizes these self-described gender identities as "women and other birthing people." The word "women" is occasionally used alone when quoting other sources. When LGBTQIA is used, it represents lesbian, gay, bisexual, transgender, queer, intersex, agender and asexual individuals.[3, 4] This language usage has been reviewed and vetted by leaders in the LBGTQIA birth worker community.

Executive Summary:

The New York State Association of Licensed Midwives (NYSALM) is the professional organization for licensed midwives in New York. NYSALM's mission statement is:

- To promote the health and well-being of women and infants through midwifery care
- To facilitate the professional practice of Licensed Midwives in the State of New York
- To encourage and maintain collegial relationships with healthcare providers, institutions, and organizations related to women's health

Midwives in all practice settings are committed to improving safety and providing high quality healthcare. This vision is shared by women and other birthing people, consumer advocates, obstetrical consultants, and other members of the healthcare team. Midwifery practice for families that choose planned home birth (PHB) upholds these goals.

In keeping with its mission, NYSALM has developed a document for midwives to use which highlight best practice when caring for families planning childbirth in the home setting. The document meets the following objectives:

1. Describe background information and context of PHB in New York State
2. Outline elements of routine prenatal, intrapartum, postpartum and newborn care provided by midwives for essentially healthy individuals for PHB
3. Define how midwives use collaborative relationships when attending PHB, and the process and indications for which consultation, collaboration and transfer of care (CCT) are recommended
4. Highlight national best practice guidelines for care during transfers from a PHB to a hospital
5. Offer tools for use with transfers of care for improving communication and quality reviews

Additionally, articulating these approaches for quality care for PHB will help educate consumers about recommended practice. Midwives in New York are independent providers for complete routine care. Consumers will be informed that midwives facilitate a team approach for accessing advanced care, and facilitate putting them at the center of their care planning when collaborative care is indicated.

Furthermore, these documents will provide obstetricians, other physician specialists, hospital-based midwives, nurses, health-system planners, and hospital administrators with basic information to respond appropriately to the needs of women, other birthing people, and their newborns when advanced care is indicated. Planned home birth is recognized to have the best outcomes when practiced within a healthcare system that integrates and coordinates with midwives to meet the needs of families that make this choice.[5]

Hallmarks of quality midwifery care include facilitating shared decision-making, and individualization of care. Midwives utilize the information within these evidence-based documents as they exercise clinical judgment and facilitate this individualization. The information herein should not be construed as dictating an exclusive course of action to be followed.

Document Development Process:

A committee of seven midwives, who are also board members of NYSALM, undertook weekly meetings for over a year to update the 2011 NYSALM Planned Home Birth Statement. Work started with an analysis of existing barriers to integration of PHB within the healthcare system.

Next, a survey was sent to the entire NYSALM membership requesting feedback about the need for planned home birth guidelines. In eight weeks, there were 89 responses from midwives working in a variety of settings reflecting varied insights and concerns. These were considered during the development of these documents. Of those who responded, 45% worked in hospitals and 33% attended home births. A strong majority, 70%, agreed that guidelines for PHB are important, including establishing criteria for consultation, collaboration and transfer of care.

Reflecting the objectives above, a concept map was developed balancing the ethical and clinical factors related to midwifery practice for PHB for clients and their families, midwives, and collaborators:

- Midwives independently provide routine assessment and care for essentially healthy women, other birthing people, and their newborns
- Midwives recommend and facilitate appropriate care within collaborative relationships when conditions develop that warrant advanced clinical opinion or care
- Midwives and collaborators engage clients in shared decision-making about their care

The process and steps to develop this evidence-based document were modeled upon the Institute of Medicine's *Clinical Practice Guidelines We Can Trust: Standards for Developing Trustworthy Clinical Practice Guidelines*.[6]

Policy statements on PHB from relevant professional and public health organizations were surveyed. Inclusion criteria identified documents from midwifery organizations with guidelines listing indications for CCT. Saturation was expected with inclusion criteria when sources were limited to United States and international jurisdictions with regulated midwifery practice, where published studies demonstrated safety or cost effectiveness of PHB practice. These included guidelines from organizations in Washington State, the Netherlands, the United Kingdom, and British Columbia, Canada. It was also deemed appropriate to include indications for CCT from Upstate New York Home Birth Midwives Consortium, and the ACOG/AAP Guidelines for Perinatal Care.

Guidelines for Indications for Consultation, Collaboration and Transfer of Care was formulated from a spreadsheet tabulation of indications for CCT drawn from these regional exemplars. This identified 240 possible conditions. When various approaches were identified from the regional guidelines, clinical evidence was reviewed. Conditions were then sorted into three categories:

1. General medical conditions impacting perinatal well-being
2. Select conditions highlighted as recommended for hospital birth (Table 1)
3. Conditions recommended for consultation, collaboration or transfer of care, in which the client, midwife and consultant jointly develop the individualized care plan (Table 2)

Routine Midwifery Care when Facilitating Planned Home Birth was iteratively developed with 20 midwives describing their routine practice. The resulting outline was compared against the ACNM Standards of Practice, the New York State Department of Health Medicaid Prenatal Care Standard, and the New York Midwifery Practice Act.

After the committee prepared the document, the draft was circulated for structured review from stakeholders within various disciplines. Reviewers were asked if the sections of the document represent best current evidence, and whether items should be added or omitted. Input was received from reviewers representing biomedical ethics, maternal-fetal medicine, obstetrics, neonatology, pediatrics, family medicine with obstetrical practice, hospital-based nursing and midwifery, and representatives of four statewide consumer advocacy groups. Reviewers' comments were collated into 32 pages. Each comment was assessed and, when appropriate, incorporated into the language of the document. The document was subsequently reviewed and amended by four legal teams specializing in health systems, litigation and regulation.

The document was trialed by midwives serving in the home setting for a period of one year. Thereafter, midwife users were surveyed for suggested updates. Expert reviewer input related to gender inclusive language was also obtained from leaders within LBGTQIA birth worker communities. The document was edited and released in final form in October 2017. These documents reflect practice as of the date issued, which may be subject to change with evolving evidence.

Midwifery Practice for Planned Home Birth

Childbearing families choose to birth at home for quality of care.
Quality of care indicators such as support for physiologic birth,[7] lower intervention rates, continuity of provider, and the ability to personalize care lead many consumers to experience high levels of satisfaction. These hallmarks of midwifery practice also enhance safety[8], and are among the primary reasons women and other birthing people choose to birth at home.[9]

The benefits of planned home birth with qualified midwives are supported by best evidence.
The best quality studies for examining the safety of planned home birth (PHB) must meet specific criteria.[10] Quality studies that seek to evaluate PHB as practiced in New York State must exclude unintended out-of-hospital birth from the PHB cohort; participants must be those who receive complete care throughout the childbearing cycle from qualified licensed providers with legal use of appropriate safety equipment and ready access to consultation with obstetrical providers.

When these specific circumstances are met, studies of PHB show excellent outcomes and very low rates of intervention.[11, 12] Such studies show lower rates of induction or augmentation, epidural anesthesia, operative vaginal delivery, cesarean section, and episiotomies.[12-14] Newborns born at home have lower incidence of resuscitation and rates of perinatal death are very low and are comparable to those in hospital births.[13, 16] An annotated literature review related to planned home birth is regularly updated.[11] Additional review of the evidence is described in the ACNM clinical bulletin *Midwifery Provision of Home Birth Services.*[17]

The right to choose planned home birth has overwhelming health policy support.
International and national maternal-child health organizations focus on supporting best quality services when families plan home births. Such organizations include, but are not limited to:
American Association of Pediatricians (AAP)[16]
American College of Nurse-Midwives (ACNM)[17, 18]
American College of Obstetricians and Gynecologists (ACOG)[5]
American Public Health Association (APHA)[19]
Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)[20]
Coalition for Improving Maternity Services (CIMS)[21]
Childbirth Connection / National Partnership for Women and Families[22]
Home Birth Summit (HBS)[23]
International Confederation of Midwives (ICM)[24]
Midwives Alliance of North America (MANA)[25]
National Institute for Health and Care Excellence (NICE)[26]
National Perinatal Association (NPA)[27]
World Health Organization (WHO)[28]

Midwives licensed by New York State are recognized as qualified planned home birth providers.
Licensed Midwives (LM) are independent care providers as authorized by the Midwifery Practice Act. Midwifery scope of practice includes "management of normal pregnancies, childbirth and postpartum care as well as primary preventive reproductive health care of essentially healthy women, and... [includes] newborn evaluation, resuscitation and referral for infants."[29] Licensed midwives "practice in a wide variety of settings including hospitals, clinics, birth centers, clients' homes, and private professional offices."[30] Licensed midwives have advanced degrees from nationally accredited midwifery programs that meet New York State educational standards. Midwives must pass a licensing exam and are nationally board certified. Maintaining certification requires continuing education. The New York State Office of the Professions charges the Board of Midwifery with assuring the safety of the public through licensure, regulation, and review of complaints.[31]

Midwives create a culture of safety by providing comprehensive care.
Monitoring well-being throughout the childbearing cycle is integral to midwifery care. In New York, model midwifery practice incorporates *NYSALM Routine Midwifery Care when Facilitating Planned Home Birth*. Midwives provide comprehensive prenatal care, including ordering ultrasounds, laboratory and genetic testing. Midwives deliver continuity and hands-on clinical care, monitoring during active labor and birth, and lactation support during the postpartum period. Care is focused on evidence-based, physiologic principles.[32] Clinically appropriate interventions and emergency measures are used when indicated.

Midwives use ongoing screening to promote healthy outcomes.
In New York State, model midwifery practice utilizes *NYSALM Guidelines for Consultation, Collaboration and Transfer of Care for Planned Home Birth*. The guidelines set forth in this document, along with the midwife's clinical judgment, are utilized for assessing which clients are good candidates for a PHB, as well as for providing ongoing care. The best candidates for PHB are essentially healthy, with a full-term, singleton fetus in cephalic presentation.[17] These individuals and their partners also demonstrate the knowledge, capacity, and judgment to choose PHB, and adapt to the changeable nature of pregnancy, labor, birth, and newborn transition.[17]

Midwives facilitate quality care by engaging in a shared decision-making process with clients.
Quality care places clients at the center of their care.[1,2,33-35] Clients are understood to be the decision makers for themselves and their fetuses or newborns. They consider their own experiences, values, and cultural perspectives, and assess the benefits expected from having a PHB, as well as personal risks. Client-centered care generally results in better health outcomes and higher levels of satisfaction.[33]

The right to personal bodily integrity and self-determination is intrinsic to midwifery and obstetrical professions, and is a foundational principle within organizations responsible for promoting quality care.[1,2,17, 25, 33-38] Shared decision-making grows out of the ethical principle of autonomy. Midwives engage clients and their families in shared decision-making to promote individualization of care within the midwifery scope of practice. Professional midwifery practice and clients' desires are typically aligned. Therefore, midwives honor the decisions of clients as long as the following conditions are met:

- Midwives and clients engage in a thorough process of evidence-based informed consent and shared decision-making. Clients sign forms documenting the decision-making process.
- Shared decision-making does not require midwives to compromise their personal or professional integrity or engage in professional misconduct.[39]
- Clients demonstrate understanding and willingness to accept responsibility for the potential risks and results of their decisions, when the midwife has recommended a plan of care for which the client exercises informed decision-making and refusal.[38]

Midwives facilitate equity for under-served populations and address disparities in outcomes.
The individualization of care and extended prenatal contacts that midwives provide at PHB is ideal for meeting unique needs of families within their cultural context. Personal values, religious and cultural expressions, and community-specific clinical needs are identified and addressed. Examples abound: Single parent families are provided additional supportive resources and referrals. Survivors of sexual abuse are offered care which protects the centrality of personal control over bodily integrity and privacy. The outcome disparities for individuals within Black and other communities of color are improved through intensive, community-focused care and support.[40, 41] Immigrants, refugees, international students, and undocumented persons are offered privacy and culturally-sensitive care. Religious populations such as Amish and Mennonite, Muslim, and Orthodox Jewish observe their religious practices throughout the childbearing cycle. LGBTQIA people receive support and non-judgmental care, including affirmation of non-traditional family structures and the full spectrum of gender identities. Midwives serving at PHB provide increased access to care for families throughout rural counties and urban settings facing maternity care deserts.

Midwives have collaborative relationships with physicians and transport to hospitals when higher level care is indicated.
The evidence for quality PHB services highlights the responsibility of the midwife and local perinatal system to coordinate communication and collaboration to achieve optimal outcomes. [6, 13, 15, 42] As primary care providers, midwives utilize clinical judgment and provide ongoing screening. When conditions arise that warrant advanced care, midwives facilitate the appropriate consultation, collaboration, or transfer of care (CCT) according to the guidelines set forth in the documents *NYSALM Guidelines for Consultation, Collaboration and Transfer of Care* and the *HBS Best Practice Guidelines: Transfer from Planned Home Birth to Hospital*.[22, 29, 42-45]

Summary
Physicians and midwives have a long history of working together to promote healthy outcomes throughout the childbearing cycle. The best available evidence and public health policy recommendations support planned home birth as a reasonable option for those who seek a physiologic birth. The highest quality of care occurs with inter-professional coordination across care settings.

Routine Midwifery Care Facilitating Planned Home Birth

Routine care for planned home birth is provided by a licensed midwife during antepartum, intrapartum, postpartum and newborn periods. The midwife uses clinical judgment to integrate the content of routine midwifery care within the ACNM Standards of Practice, community-specific standards, and individualized shared decision-making. Hallmarks of routine care demonstrate support for normal physiologic birth and ongoing assessment. The midwife identifies conditions that need advanced care and timely consultation, collaboration or transfer of care to promote healthy outcomes. Routine care also encompasses management of sudden complications using first-line emergency measures according to evidence-based practice. The following outline describes the typical scope and content included in routine midwifery care for essentially healthy women, other birthing people, and their newborns for planned home birth.

Midwifery Care
- Evaluating subjective and objective data to formulate assessments/diagnoses, and developing, implementing, and modifying plan of care, documenting course of care
- Facilitating culturally-sensitive care, health education, and client-centered shared decision-making
- Promoting physiological wellness and utilizing technological interventions as indicated
- Arranging for physician consultation, collaboration, or transfer of care, as indicated

Antepartum Care
- Initial Screening: history, physical, psychosocial, substance use, nutritional assessment
- Laboratory and Ultrasound: genetic, diagnostic, fetal surveillance, routine and as indicated
- Prenatal Checkups and Relationship Development:
  - Frequency: approximately monthly to 28 weeks, twice monthly to 36 weeks, weekly until birth
  - Routine Prenatal Assessment: dating, weight, BP, fundal height, fetal heart rate, fetal lie, presentation, and position
  - Health Education: wellness, nutrition, exercise, parenting, vaccinations, HIV and prenatal testing options, advance directives
  - Childbirth Preparation: physiologic birth principles, home birth supplies, home visit
  - Contingency Planning: emergency plan, transfer procedures, medical treatments used at home and in hospitals, emotional preparation for transfer
  - Community Resources and Referrals: genetic counseling, social services, psychotherapy, complementary health providers [46]

Intrapartum Care

- Licensed Midwife and assistant on call 24/7; Licensed Midwife present during active labor
- Labor Monitoring: labor history, physical examination, vital signs, contractions, membrane status, emotional support
- Fetal Monitoring: presentation and position, movements, intermittent FHR auscultation[47]
- Supportive Care:
  - Ambulation: walking and position changes
  - Intake and Output: water, caloric fluids, light foods, voiding, vomiting
  - Physical/Emotional Support: hands-on presence, reassurance, massage, hydrotherapy, transcutaneous electrical nerve stimulation, etc.
  - Facilitating Birth: promoting physiologic labor and birth, protecting the perineum
  - Facilitating Newborn Transition: Apgar, respiration, thermoregulation, sterile cord clamping
- Management and Interventions, as indicated, during birth and postpartum periods:
  - Vaginal exams, amniotomy, urinary catheterization, nipple stimulation, episiotomy, IV fluids, GBS prophylaxis, oxytocic agents in third or fourth stages, newborn suctioning, oxygen administration, PPV, CPR, manual placental removal, repair of laceration or episiotomy, complementary health approaches,[46] among others

Immediate Postpartum Care

- Postpartum Monitoring/Care: vital signs, fundus, lochia, estimated blood loss, newborn feeding and bonding, ambulation, urination, food intake, showering and self-care
- Newborn Monitoring/Care: vital signs, weight and measurements, feeding and bonding, comprehensive newborn examination, gestational age assessment, vitamin K and eye prophylaxis
- Health Education: monitoring of self and baby, indications to call midwife, baby care and feeding
- Client and newborn will remain under care until stabilized; appropriate personal support thereafter

Follow-up Postpartum Care

- Routine Home Visits: at 1-2 days and 3-5 days, offered at 1-2 weeks, additional visits as needed
- Postpartum Monitoring/Care: vital signs, involution, lochia, perineum, lactation, depression screening
- Newborn Monitoring/Care: vital signs, perfusion, jaundice, weight, cord, output, feeding, critical congenital heart disease screening, metabolic screening, birth certificate, plan for well-baby care with primary care provider by 2-4 weeks
- Final 6-8 Week Visit: physical/emotional assessment, plan for follow-up primary care, Pap and labs, contraception, as indicated

Quality Assurance

- Maintaining individual practice guidelines for routine and collaborative care
- Participating in uniform data collection, benchmarking, and peer review
- Maintaining certifications in neonatal resuscitation and cardiopulmonary resuscitation
- Participating in obstetrical emergency drills
- Providing outreach to and care access for diverse communities

Guidelines for Consultation, Collaboration and Transfer of Care for Planned Home Birth (CCT)

Midwives utilize clinical judgment and ongoing assessment throughout the childbearing cycle, including selection of clients appropriate for planned home birth. Midwives identify conditions that need advanced care to promote healthy outcomes. When these situations are identified, the midwife provides evidence-based information to the family about care options, facilitates client-centered shared decision-making, and recommends timely consultation, collaboration, and/or transfer of care (CCT) with the appropriate specialty provider. The client, midwife, and consultant jointly develop the care plan with the appropriate level of CCT. The resulting plan of care may be implemented by the midwife or may result in a complete transfer of care to a hospital-based provider.[17]

In accord with the NY Midwifery Practice Act, midwives maintain collaborative relationships with obstetrical physicians.[29] Additionally, as appropriate to addressing specific needs of the client, midwives facilitate access to other members of the health care team, including specialty physicians, hospital-based midwives, nurse practitioners, lactation consultants, counselors, and nutritionists, among others. Midwives have established plans for accessing higher level care in delivery and neonatal hospital facilities. Women and other birthing people may seek medical consultation at any time for any reason. Relevant records of prior midwifery care are made available. Documentation of CCT is made in the client's record.

During the prenatal period, the midwife works with every client to develop a home-to-hospital transfer plan that is recorded in the client's medical record. Midwives educate and prepare clients and families about transfer possibilities and hospital procedures. Midwives interact with other providers in setting a collaborative tone and promoting client-centered care. Midwives encourage clients and families in accepting the new setting, providers, and care plan. When possible, midwives remain accessible to facilitate physician-patient communication and understanding.

Figure 1. Coordination of communication and teamwork between community midwives and hospital-based providers and staff promote a positive feedback loop resulting in enhanced quality of care for women, other birthing people, and their newborns.

Midwives and the families within their care expect to engage with a healthcare system and providers who are focused on respectful, quality care. The federal Emergency Medical Treatment and Labor Act (EMTALA)[48] requires that a medically unstable or laboring patient will receive assessment and stabilizing care at the transfer hospital. The national *Home Birth Summit Best Practice Guidelines: Transfer from Planned Home Birth to Hospital*, Appendix B, provide standards for coordination of communication and care between midwives attending PHB, and hospital-based physicians, midwives and staff who receive transfers.[49]

New York State midwives define CCT for planned home birth as follows:[45]

Consultation is the process initiated by the midwife so the client may receive a clinical opinion or care from a physician or another member of the health care team. The consultant typically has a visit with the client, or may review the medical record. A written report is provided to the midwife, who maintains primary responsibility for the client's care.

Collaboration is the process whereby a midwife and physician jointly manage the care when medically indicated, fostering together meaningful engagement of the client in care planning. Effective communication between the midwife and physician about practice roles and the care plan is essential for ongoing collaborative management. When the midwife has hospital privileges, the midwife may continue as the primary provider within the collaborative system of care. When the physician assumes a lead role, the midwife may assist with teaching and support.

Transfer of Care is the process whereby the midwife directs the client to a physician or another healthcare professional for management of a particular condition or aspect of care.

CCT is indicated for any client with medical or psychological conditions showing evidence for potential significant impact on perinatal health.

Table 1. **Examples of Indications Recommended for Intrapartum Hospital Care**.
The midwife provides families with information within the shared decision-making format, recommending intrapartum hospital care.

Multiple gestation
Non-cephalic presentation in labor
Prior uterine surgery**
Preterm labor < 37 weeks
Post term pregnancy without labor > 42/0 weeks
Plan for pharmaceutical induction or augmentation

** The decision for place of birth when there is a history of cesarean section is influenced by a number of factors, including clinical assessment, professional recommendations, availability of support for vaginal birth after cesarean (VBAC) in the local hospital, and the client's personal experiences, values, and sense of safety. Consumers may seek VBAC at home, in light of recent evidence from a national PHB data set reporting, "Women with a history of both cesarean and vaginal birth fared better than primiparas across all outcomes; however, women with a history of cesarean but no prior vaginal births had poor outcomes, most notably fetal/neonatal demise." [50] Clinical guidance for VBAC is beyond the scope of this document. As appropriate for any condition with significant potential to impact perinatal health, midwives will facilitate a process of enhanced shared decision-making, including recommending obstetrical consultation to facilitate hospital transfer planning, promoting adaptability in the birth plan in light of the changeable nature of birth, and delineating clinical parameters associated with best outcomes, as well as those warranting timely transfer to hospital. Clients, their partners, and midwives will document the content of the decision-making process.

Table 2. **Additional Indications for Consultation, Collaboration, or Transfer of Care**
The indications listed serve as professional guidelines for CCT in the context of planned home birth. The midwife implements timely consultation, collaboration, and/or transport to a hospital in accordance with the midwife's clinical judgment and locally available resources.

Previous Medical or Obstetrical History
Active health conditions under treatment or impacting perinatal outcome
Morbid obesity
Reproductive tract abnormalities
Major gynecological surgery
Preterm birth
Infant with documented fetal growth restriction or low birth weight
Infant with congenital or hereditary disorder
Infant with shoulder dystocia
Unexplained stillbirth or neonatal death
Placental abruption
Severe hypertensive disorder in pregnancy
Perinatal hemorrhage requiring transfusion
Isoimmunization
3 or more miscarriages

Antepartum Conditions
Development of any conditions listed above
Pap or clinical breast exam needing further assessment
No prenatal care at term
Exposure to teratogens or substance abuse including tobacco or prescription medications
IUD in situ
Hyperemesis gravidarum
Significant vaginal bleeding
Incomplete spontaneous abortion
Hydatidiform mole
Ectopic pregnancy
Anemia unresponsive to treatment at term
UTI unresponsive to treatment
Pyelonephritis
Primary genital herpes infection
Gestational diabetes uncontrolled by diet/exercise
Hypertensive disorders
Thrombocytopenia
Thromboembolic disease
Confirmed fetal growth restriction
Confirmed oligohydramnios or polyhydramnios
Abnormal fetal surveillance
Fetal demise
Placental abnormalities

Intrapartum Conditions
Development of any conditions listed above
Abnormal vaginal bleeding
Hypertensive disorders
Seizure, Anaphylaxis, VS Instability
Prolonged prelabor rupture of membranes at term without labor[51]
Evidence of chorioamnionitis or infection
Active genital herpes
Suspected uterine rupture
Prolapsed umbilical cord
Thick particulate meconium
Unresolved fetal heart rate abnormalities
Fetal demise
Mother's request for pain medication or hospitalization

Postpartum Conditions
Lacerations requiring extensive or complex repair
Retained placenta
Hypertensive disorders
Seizure, Anaphylaxis, Shock
Unresolved vital sign instability
Hemorrhage unresponsive to therapy
Thromboembolic disease
Retained uterine contents
Endometritis or unexplained fever
Mastitis unresponsive to therapy, abscess
Uterine prolapse or inversion

Newborn Conditions
Apgar < 7 at 5 min
Unresolved respiratory distress
Use of extensive resuscitative measures
Central cyanosis
Persistent temperature instability or hypotonia
Abnl heart rhythm, murmur, or CCHD Screen
Evidence of prematurity or LBW (< 5.5 lbs)
Loss of > 10% of body weight; slow gain
Jaundice < 24 hrs, pathological jaundice
Suspected seizure activity
Anomalies requiring immediate treatment
Abnormal blood clotting
Suspected infection

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APPENDIX Ai: Optional Clinical Record Summary for Transfer from Planned Home Birth to Hospital

Summary of Record for Transfer from Planned Home Birth to Hospital

SITUATION

Name_____

DOB_____ Age_____

G_____ P_____ EGA_____ EDD_____

❑ **Transfer Mother -- Stage**_____

❑ **Transfer Newborn -- Age**_____

Reason for Transfer_____

_____

Transfer Via: ❑ Car ❑ EMS ETA_____ ❑ Urgent

Request Admit: ❑ LD ❑ OR ❑ NICU ❑ Provider to ED

Midwife _____

Phone Contact _____

TRANSFER RECORD

Date_____ Time of Call_____ Call Made by_____

Receiving Hospital_____

Hospital Staff Receiving Call_____

Receiving Provider_____

Other Receiving Hospital Staff_____

❑ Transfer by Private Car: Time Departed Home_____

❑ Transfer by EMS: Called_____ Arrived_____ Departed_____

EMS Staff_____

Time: Arrival at Hospital Door_____ L&D Room_____

Time: Receiving Provider Present _____ Verbal Report_____

Medical Records provided, #pages_____ ❑ Records at Hospital

BACKGROUND – Medical and Antenatal History as Relevant

Significant Medical History_____

Medications/Supplements_____ Allergies_____

Prior Pregnancy Outcomes_____

Significant Prenatal History_____

Baseline BP_____ Ultrasound_____

Lab Review: Type/Rh_____ Hg or Hct_____ RPR_____ HIV_____ HBSAg_____ Rubella_____ GBS_____ (date_____)

Glucose_____ Fetal Screen_____

Other:_____

BACKGROUND – Labor History -- Date and Time

Latent Labor Onset_____ Duration_____

Active Labor Onset_____ Duration_____

Second Stage Onset_____ Duration_____

Birth_____

_____

Membranes ROM_____ Duration_____

Placenta Delivered_____ Duration_____

Other:_____

_____

BACKGROUND -- Most Recent Physical Findings

Last VS: Time_____ BP_____ P_____ T_____ R_____

Contraction Pattern_____

Cervix Exam: Time_____ cm_____ %_____ soft / firm

Fetus: Station_____ Position_____ Caput_____

Fetal Heart: Time_____ FHR_____

Membranes: ❑ Intact ❑ SROM ❑ AROM ❑ Color_____

Placenta Intact: ❑ Yes ❑ No _____ Est Blood Loss_____

Perineum: ❑ Intact ❑ Episiotomy ❑ Laceration_____

Other:_____

BACKGROUND – Procedures

IV: Time_____ Volume_____ Cannula Size_____

GBS: Antibiotic_____

Times/Doses_____

Hemorrhage:

Medications _____

Procedures _____

Sutures: _____

Other:_____

BACKGROUND – NEWBORN ❑ NA: Not Transferred (with Mother)

Name_____ ❑ Female ❑ Male

Apgar: 1 min_____ 5 min_____ 10 min_____ Birth Weight_____

Last VS: Time_____ Heart Rate_____ Resp Rate_____ Temp_____

Feeding_____ Time Last Feed_____

Resusc: ❑ Suction ❑ O2 ❑ PPV ❑ Chest Comp. ❑ SPO2_____

❑ Vitamin K _____ ❑ Eye Tx ❑ Blood Glucose_____

❑ Metabolic Screening ❑ CCHD Screen ❑ Jaundice_____

Other:_____

ASSESSMENT—MATERNAL

_____

ASSESSMENT – NEWBORN

_____

RECOMMENDATIONS FOR CARE (Care and personnel likely needed upon arrival.)

_____

Completed By_____ Title_____ Date/Time_____

APPENDIX Aii: Optional Questionnaires for Quality Improvement Review of Transfer Experience

a. Feedback Questionnaire: Midwife to Hospital Provider and Staff

Dear Midwife,

We know that transferring to hospital care was not your client's first plan. We aim to make the experience positive for all involved. Your feedback helps us adjust our care for the best possible outcomes, and is important to us. You may email your responses to_____.
Or, you may return it by mail to_____.

Thank you for entrusting us with the care of your client.

Sincerely, Hospital Provider or Staff _____

Midwife Name/Contact Information: _____

Date of transfer:_____

How did the transfer of care go?

What was the reason for transfer from home to hospital? What was the outcome?

Evaluate the communication between yourself, the nurses and receiving provider when first giving report, and throughout the client's hospital stay.

What went well?

What could be improved upon, or do you have any concerns?

Would you like to participate in a transfer of care case review for this event?

Anything else?

APPENDIX Aii: Optional Questionnaires for Quality Improvement Review of Transfer Experience

b. Feedback Questionnaire: Hospital Provider and/or Staff to Midwife

Dear Hospital Providers and Staff,

I know that receiving a transfer from a planned home birth is uncommon. My aim is to make the experience positive for all involved. Your feedback helps me adjust care for the best possible outcomes, and is important. You may email your responses to_____.
Or, you may return it by mail to_____.

Thank you for receiving the transfer and caring for my client.

Sincerely, Midwife_____

Hospital Name: Receiving Provider:

Date of Transfer:

How did the transfer of care go?

What was the reason for transfer from home to hospital? What was the outcome?

Evaluate the communication between yourself, your staff, and the midwife when first receiving report, throughout the client's hospital stay.

What went well?

What could be improved upon, or do you have any concerns?

Would you like to participate in a transfer of care case review for this event?

Anything else?

APPENDIX Aii: Optional Questionnaires for Quality Improvement Review of Transfer Experience

c. Feedback Questionnaire: Family Experiencing Transfer from Planned Home Birth to the Hospital Staff or Midwife

Dear _____ ,

We know that transferring to hospital care was not your first plan. Your feedback helps us adjust our care for the best possible outcomes, and is important to us. Both your hospital providers/staff and your midwife would like to understand your experience of the transfer. You may offer the same feedback to both the hospital's provider/staff and your midwife. Alternatively, you may offer separate feedback on two questionnaires for the hospital's provider/staff and your midwife.

You may use this sheet and return it to the charge hospital nurse or receiving provider. You may also email your responses to_____. You may also use this sheet and return it to your midwife. You may also email your responses to _____.

Hospital Name: Receiving Provider:

Midwife Name: Date of Transfer:

How did the transfer of care go?

What was the reason you were transferred from home to hospital? What was the outcome?

Evaluate the communication between yourself, the hospital provider and the midwife when first arriving and setting up a new care plan? Throughout your hospital stay?

What went well?

What could be improved upon, or do you have any concerns?

Anything else?

APPENDIX B

Home Birth Summit
Best Practice Guidelines:
Transfer from Planned Home Birth to Hospital

www.homebirthsummit.org

> *"We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes. All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. When ongoing inter-professional dialogue and cooperation occur, everyone benefits."*[1]

The statement above from the Home Birth Consensus Summit serves as the foundation for the following guidelines on transfer from planned home birth to hospital. These guidelines were developed by a multidisciplinary group of home and hospital based providers and stakeholders who were delegates at the national Home Birth Consensus Summits in 2011 and 2013. These guidelines are informed by the best available evidence on risk reduction and quality improvement and by existing regional policy and practice documents addressing transfer from home to hospital. [2-19]
The purpose of these guidelines is twofold:

1. To highlight core elements to be included when developing documents and policies related to transfer from home to hospital.
2. To promote the highest quality of care for women and families across birth settings via respectful inter-professional collaboration, ongoing communication, and the provision of compassionate family-centered care.

Collaborative care throughout the antepartum, intrapartum, and postpartum periods is crucial to safety whenever birth is planned outside the hospital setting. Coordination of care and communication of expectations during transfer of care between settings improve health outcomes and consumer satisfaction. [20-34]

State-specific hospital regulations and the Emergency Medical Treatment and Labor Act (EMTALA)[35] establish the legal framework for requiring access to hospital care in the United States. The legal recognition of providers of maternity care services varies between states. However, each woman seeking care at any point during the maternity cycle has the right to optimal and respectful care regardless of her planned birth setting, the persons she selects to be part of the process, or state provider regulations.

These guidelines are appropriate for births planned at home or in a freestanding birth center. Furthermore, we recognize not all providers of home birth or birth center services are midwives. However, we use the term midwife herein because the vast majority of providers of home birth or birth center services identify as midwives.

Model practices for the midwife

- In the prenatal period, the midwife provides information to the woman about hospital care and procedures that may be necessary and documents that a plan has been developed with the woman for hospital transfer should the need arise. [15]
- The midwife assesses the status of the woman, fetus, and newborn throughout the maternity care cycle to determine if a transfer will be necessary.
- The midwife notifies the receiving provider or hospital of the incoming transfer, reason for transfer, brief relevant clinical history, planned mode of transport, and expected time of arrival. [11,13-16,19]
- The midwife continues to provide routine or urgent care en route in coordination with any emergency services personnel and addresses the psychosocial needs of the woman during the change of birth setting.
- Upon arrival at the hospital, the midwife provides a verbal report, including details on current health status and need for urgent care. The midwife also provides a legible copy of relevant prenatal and labor medical records. [11,12,15,16,19]
- The midwife may continue in a primary role as appropriate to her scope of practice and privileges at the hospital. Otherwise the midwife transfers clinical responsibility to the hospital provider. [13]
- The midwife promotes good communication by ensuring that the woman understands the hospital provider's plan of care and the hospital provider understands the woman's need for information regarding care options.
- If the woman chooses, the midwife may remain to provide continuity and support.

Model practices for the hospital provider and staff

- Hospital providers and staff are sensitive to the psychosocial needs of the woman that result from the change of birth setting. [11]
- Hospital providers and staff communicate directly with the midwife to obtain clinical information in addition to the information provided by the woman. [12]
- Timely access to maternity and newborn care providers may be best accomplished by direct admission to the labor and delivery or pediatric unit. [11-15]
- Whenever possible, the woman and her newborn are kept together during the transfer and after admission to the hospital.
- Hospital providers and staff participate in a shared decision-making process with the woman to create an ongoing plan of care that incorporates the values, beliefs, and preferences of the woman.
- If the woman chooses, hospital personnel will accommodate the presence of the midwife as well as the woman's primary support person during assessments and procedures.
- The hospital provider and the midwife coordinate follow up care for the woman and newborn, and care may revert to the midwife upon discharge.
- Relevant medical records, such as a discharge summary, are sent to the referring midwife.

Quality improvement and policy development

All stakeholders involved in the transfer and/or transport process, including midwives based at home or in the hospital, obstetricians, pediatricians, family medicine physicians, nurses, emergency medical services personnel, and home birth consumer representatives, should participate in the policy development process. Policies and quality improvement processes should incorporate the model practices above and delineate at a minimum the following:

- Communication channels and information needed to alert the hospital to an incoming transfer.
- Provision for notification and assembly of staff rapidly in case of emergency transfer.
- Opportunities to debrief the case with providers and with the woman prior to hospital discharge.
- Documentation of the woman's perspective regarding her care during transfer.
- A defined process to regularly review transfers that includes all stakeholders with a shared goal of quality improvement and safety. This process should be protected without risk of discovery. [12]
- Opportunities for education regarding home birth practice, shared continuing medical education, and relationship building that are incorporated into medical, midwifery and nursing education programs. Multi-disciplinary sessions to address system issues may enhance relationship building and the work culture.
- Quality of care is improved when policies and procedures are in place to govern best practices for coordination and communication during the process of transfer or transport from a home or birth center to a hospital.[2-10]

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