NEW YORK STATE ASSOCIATION OF LICENSED MIDWIVES

BIRTH IN THE COMMUNITY SETTING IN NEW YORK STATE: NYSALM Guidelines for Best Practice

New York State Association of Licensed Midwives

NYSALM Quality Committee
and
Home Birth Integration Initiative

Released for Trial October 2015
Finalized October 2017
Updated for Community Birth, May 2020

newyorkmidwives.com

Contents

NYSALM'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) or midwifery-led birth centers (MBC) upholds these goals. Collectively, perinatal care provided in the home or birth center is called *birth in the community setting*.[8] As perinatal care in both settings is conducted with similar staffing, equipment and standards, NYSALM will treat them together for the purposes of describing and defining quality healthcare.

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

1. Review background information and context for birth in the community setting in New York State
2. Outline elements of routine prenatal, intrapartum, postpartum and newborn care provided by midwives for essentially healthy individuals for birth in the community setting
3. Define how midwives use collaborative relationships when attending birth in the community setting, 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 births in the community setting 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 can 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 specialty care, 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. Birth in the community setting 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 who make this choice. [5,6]

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:

In 2015, a committee of seven midwives, who were 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 guidelines related to PHB practice. 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*.[7]

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 CCT, 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.

In spring of 2020, the document was revised to reflect clinical updates and address the emergence of midwifery-led birth centers, resulting from changes to the New York State statue and regulations. The core indicators for collaborative care were reviewed alongside current standards, as well as the standards of the American Association of Birth Centers (AABC) and the Commission for Accreditation of Birth Centers (CABC).

These documents reflect practice as of the date of issue, which may be subject to change with evolving evidence.

Midwifery Practice for Birth in the Community Setting

Consumer choice for perinatal care includes birth in the hospital, birth center and home settings.
The most common setting or birth is hospitals. Birth center facilities are separate from the hospital. Families may also plan childbirth in a private home. Collectively, perinatal care provided in a birth center or home is called *birth in the community setting*.[8] Both community settings provide for common hallmarks: midwives as independent primary care providers, complete perinatal care, support for physiologic birth and newborn transition, wellness monitoring, preventive health education, judicious clinical interventions, and collaborative relationships with specialty providers for higher level care.[9]

Childbearing families choose to birth in the community setting for quality of care.
Quality of care indicators such as support for physiologic birth,[10,11] 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,[12] and are among the primary reasons women and other birthing people choose to birth in the community setting.[13,14]

The benefits of community birth with qualified midwives are supported by best evidence.
Where perinatal systems integrate the choice of birth settings, a recent meta-analysis of highest quality evidence demonstrates that place of birth does not statistically impact rates of infant mortality for low-risk pregnancies, but lowers risk of maternal morbidity and interventions.[15]

Midwifery-led birth centers (MBC) are associated with safe outcomes and low obstetric intervention rates. In a multicenter prospective cohort study of 15,574 births, 84% gave birth at the birth center; 94% had vaginal births. The cesarean section rate after labor admission was 6%, while the national average for a comparable low-risk hospital cohort was 27%. The intrapartum fetal mortality rate was 0.47/1000 and the neonatal mortality rate was 0.40/1000. There were no maternal deaths.[16] A recent systematic review of 17 studies with over 84,000 admissions to birth centers found no difference in neonatal mortality in birth centers compared to similar risk births in hospitals.[17]

Studies examining the safety of planned home birth (PHB) must meet specific criteria.[18] Quality studies that seek to evaluate PHB as practiced in the New York State regulatory context 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, a meta-analysis of studies of PHB show comparable neonatal outcomes and very low rates of intervention.[19] Such studies show lower rates of electronic fetal monitoring, induction, augmentation, epidural anesthesia, operative vaginal delivery, cesarean section, episiotomies, labor dystocia and postpartum hemorrhage.[19-22] 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.[19,20] An annotated literature review related to PHB[23] and the ACNM clinical bulletin *Midwifery Provision of Home Birth Services*[24] summarize additional research.

The right to choose planned home birth has overwhelming health policy support.
When consumers make an informed choice for giving birth at home or in a birth center, international and national perinatal health organizations focus on perinatal system support for the provision of best-quality services, including ready access to collaborative and higher-level care. Such organizations include, but are not limited to:
American Association of Birth Centers (AABC)[25]
American Association of Pediatricians (AAP)[16]
American College of Nurse-Midwives (ACNM)[9, 24, 27]
American College of Obstetricians and Gynecologists (ACOG)[5]
American Public Health Association (APHA)[28]

Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)[29]
Coalition for Improving Maternity Services (CIMS)[30]
Childbirth Connection / National Partnership for Women and Families[31]
Home Birth Summit / Birth Place Lab (HBS)[32]
International Confederation of Midwives (ICM)[33]
Midwives Alliance of North America (MANA)[34]
National Institute for Health and Care Excellence (NICE)[35]
National Perinatal Association (NPA)[36]

Midwives licensed by New York State are recognized as qualified providers in the community birth setting.
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."[37] Licensed midwives "practice in a wide variety of settings including hospitals, clinics, birth centers, clients' homes, and private professional offices."[9] In 2016, New York enacted statute for midwifery-led birth centers, to improve access to complete perinatal care.[38] 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.[39, 40]

Midwives create a culture of safety by providing comprehensive care.
Monitoring well-being throughout the childbearing cycle is integral to midwifery care.[9] In New York, model midwifery practice incorporates *NYSALM Routine Midwifery Care when Facilitating Birth in the Community Setting.* 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.[40-42] 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 Birth in the Community Setting*. The guidelines set forth in this document, along with the midwife's clinical judgment, are utilized for assessing which clients are good candidates for birth in the community setting, as well as for providing ongoing care. The best candidates for birth in the community setting are essentially healthy, with a full-term, singleton fetus in cephalic presentation.[24] These individuals and their partners also demonstrate the knowledge, capacity, and judgment to choose birth in the community setting, and adapt to the changeable nature of pregnancy, labor, birth, and newborn transition.[24]

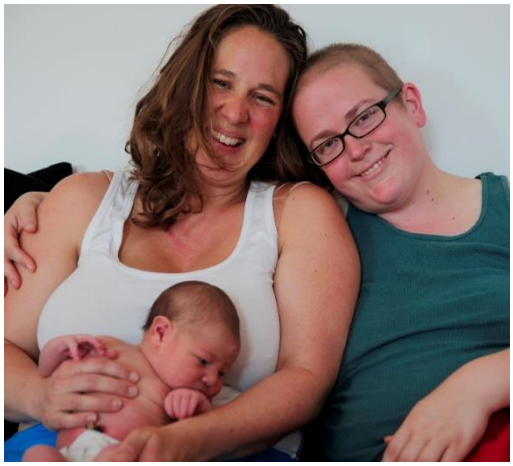
Midwives facilitate quality care by engaging in a shared decision-making process with clients.
Quality care places clients at the center of their care.[1, 2, 42-46] Clients are understood to be the decision makers for themselves and their fetuses or newborns. They consider their own experiences, values, and cultural perspectives, and assess the benefits expected from having birth in the community setting, as well as personal risks. Client-centered care generally results in better health outcomes and higher levels of satisfaction.[42]

Protecting 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.[1,2,24,34,42-47]

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.[48]
- 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.[47]

Midwives facilitate equity for under-served populations and address disparities in outcomes.



The individualization of care and extended prenatal contacts that midwives provide 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.[49, 50] People who are indigenous, immigrants, refugees, international students, or undocumented are offered culturally-sensitive care and privacy. 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 in homes and birth centers 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 services highlights the responsibility of the midwife and local perinatal system to coordinate communication and collaboration to achieve optimal outcomes. [7, 9, 20, 22, 29, 51-55] As primary care providers, midwives utilize clinical judgment and provide ongoing screening. When conditions arise that warrant specialty 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 for Birth in the Community Setting,* the *Best Practice Guidelines for Interprofessional Collaboration: Community Midwives and Specialist Providers,* (Appendix B)[56] and *HBS Best Practice Guidelines: Transfer from Planned Home Birth to Hospital*. (Appendix C).[55, 57]

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 midwifery-led care in birth centers and homes 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 Birth in the Community Setting

Routine care 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 specialty 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 births in the birth center or home setting.

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
- Prescribing drugs and devices for routine primary and perinatal care
- Counseling about options for unintended pregnancy, making referrals, providing medical abortion[58]
- Utilizing innovative care delivery methods for office, group care, telehealth
- Observing universal precautions for infection control
- 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, COVID-19 precautions, 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 [59]

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[60]
- 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, 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 3rd or 4th stages, newborn suctioning, O2 administration, PPV, CPR, manual placental removal, repair of laceration or episiotomy, nitrous oxide,[61] transcutaneous electrical nerve stimulation, complementary health approaches,[59] 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 Contacts: 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 2-6 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 Birth in the Community Setting (CCT)

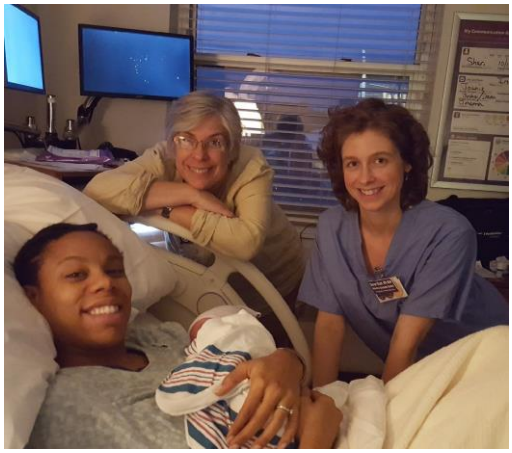
Midwives utilize clinical judgment and ongoing assessment throughout the childbearing cycle, including selection of clients appropriate for birth in the community setting. Midwives identify conditions that need advanced care to promote healthy outcomes. When these situations are identified, the midwife 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.[24, 56 ,57]

In accord with the NY Midwifery Practice Act, midwives maintain collaborative relationships with obstetrical physicians.[37] 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. *It is recommended every perinatal hospital develop internal guidelines for receiving transfers of care from midwives serving in community birth settings.* 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 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. National standards for coordination of interprofessional collaboration are outlined in the *Best Practice Guidelines for Interprofessional Collaboration: Community Midwives and Specialist Providers*,[56] (Appendix B) and the *Home Birth Summit Best Practice Guidelines: Transfer from Planned Home Birth to Hospital,* (Appendix C).[57] The federal Emergency Medical Treatment and Labor Act (EMTALA)[62] requires that a medically unstable or laboring patient will receive assessment and stabilizing care at the transfer hospital.



New York State midwives define CCT for planned home birth as follows:[54, 56]

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. Similarly, it is warranted for the midwife to consider the additive impact when several moderate conditions interact.

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. A consumer may seek VBAC at home or birth center, in light of recent evidence from a national 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." [63] When considering individualized care planning for VBAC in the community setting, 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. Complete clinical guidance for VBAC is beyond the scope of this document. Midwives are referred to other relevant standards for VBAC in the community setting, which highlight the following criteria: documented one prior low-transverse uterine scar, ultrasound confirmation of placenta remote from scar, and client health and labor status remaining otherwise within routine criteria.[64, 65]

Table 2. **Additional Indications for Consultation, Collaboration, or Transfer of Care**
The indications listed serve as professional guidelines for CCT in the context of birth in the community setting. 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[66]
Evidence of chorioamnionitis or infection
COVID-19 positive with active symptoms
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

References and Resources

References

1. Institute for Healthcare Improvement. IHI triple aim initiative: optimizing health, care, and cost. *Healthcare Exec.* 2009; Jan/Feb:64-66. IHI Website. http://www.ihi.org/engage/initiatives/TripleAim/Documents/BeasleyTripleAim_ACHEJan09.pdf Accessed April 20, 2020.
2. Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press; 2001. National Academies Website. Approved March, 2001. NCBI Website. https://www.ncbi.nlm.nih.gov/books/NBK222271/ Accessed April 20, 2020.
3. American College of Nurse-Midwives, Task Force on Gender Bias. Transgender / transexual / gender variant health care. Position Statement. ACNM Website. http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000278/Transgender%20Gender%20Variant%20Position%20Statement%20December%202012.pdf Approved December 2012. Accessed April 20, 2020.
4. Kapitan A. The radical copyeditor's style guide for writing about transgender people. Radical Copy Editor Website. https://radicalcopyeditor.com/2017/08/31/transgender-style-guide/ Posted August 31, 2017. Accessed April 20, 2020.
5. American College of Obstetricians and Gynecologists, Committee on Obstetric Practice. Planned home birth. Committee Opinion No. 697. *Ob Gyn.* 2017;129(4):779-780. doi: 0.1097/AOG.0000000000002024.
6. Lotshaw RR, Phillippi JC, et al. A collaborative model of a community birth center and a tertiary care medical enter. *Obstet Gyn*. 2020 Mar;135(3):696-702. doi: 10.1097/AOG.0000000000003723.
7. Institute of Medicine of the National Academies. Clinical practice guidelines we can trust: standards for developing trustworthy clinical practice guidelines(CPGs). National Academies Website. https://www.nap.edu/resource/13058/Clinical-Practice-Guidelines-2011-Report-Brief.pdf Approved March 2011. Accessed April 20, 2020.
8. Cheyney M, Bovbjerg ML, et al. Community versus out-of-hospital birth: what's in a name? *J Midwifery Womens Health.* 2019 Jan;64(1):9-11. doi: 10.1111/jmwh.12947
9. American College of Nurse-Midwives, Division of Standards and Practice. Definition of midwifery scope of practice of CNMs and CMs. ACNM Website. https://www.midwife.org/acnm/files/ACNMLibraryData/UPLOADFILENAME/000000000266/Definition%20of%20Midwifery%20and%20Scope%20of%20Practice%20of%20CNMs%20and%20CMs%20Feb%202012.pdf Approved December 2011. Updated February 2012. Accessed April 20, 2020.
10. The American College of Nurse-Midwives. Healthy birth initiative. ACNM Website. http://www.midwife.org/Physiologic-Birth-Initiative 2014. Accessed April 20, 2020.
11. Sakala, C, Romano AM, Buckley SJ. Hormonal physiology of childbearing, an essential framework for maternal-newborn nursing. *J Ob Gyn Neonatal Nurs*. 2016;45(2):264-275. doi: 10.1016/j.jogn.2015.12.006
12. American College of Obstetricians and Gynecologists, Committee on Obstetric Practice. Approaches to limit interventions to labor and birth. Committee Opinion No. 766. ACOG Website. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/02/approaches-to-limit-intervention-during-labor-and-birth Approved February 2019. Accessed April 20, 2020.
13. Lothian JA. Being safe: making the decision to have a planned home birth in the United States. *J Clin Ethics.* 2013;24(3):266-75.
14. Woo VG, Milstein A, Platcheck T. Hospital-affiliated outpatient birth centers: a possible model for helping achieve the Triple Aims in obstetrics. *JAMA*. 2016;316(14):1441-1442. doi: 10.1001/jama.2016.11770

15. Scarf VL, Rossiter C, et al. Maternal and perinatal outcomes by planned place of birth among women with los-risk pregnancies in high-income countries: a systematic review and meta-analysis. *Midwifery*. 2018 Jul;62:240-255. doi: 10.1016/j.midw.2018.03.024
16. Stapleton SR, Osborne C, Illuzzi J. Outcomes of care in birth centers: demonstration of a durable model. *J Midwifery Womens Health.* 2013 Jan-Feb;58(1):3-14. doi 10.111/jmwh.12003
17. Phillippi JC, Danhausen K, et al. Neonatal outcomes in the birth center setting: a systematic review. *J Midwifery Womens Health*. 2018 Jan;63(1):68-89. doi: 10.1111/jmwh.12701
18. Vedam S. Home birth versus hospital birth: questioning the quality of the evidence on safety. *Birth* 2003;30(1):57-63. PMID:12581041.
19. Rossi AC, Prefumo F. Planned home versus planned hospital births in women at low-risk pregnancy: a systematic review with meta-analysis. *Eur J Ob Gyn Reprod Biol*. 2018 Mar;222:102-108. doi: 10.1016/j.ejogrb.2018.01.016
20. Janssen PA, Saxell L, Page LA, Klein MC, Liston RM, Lee SK. Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician. *CMAJ* 2009;(6-7)181:377-83. doi: 10.1503/cmaj.081869.
21. Cheyney M, Bovbjerg M, Everson C, Gordon W, Hannibal D, Vedam S. Outcomes of care for 16,924 planned home births in the United States: the Midwives Alliance of North America statistics project, 2004 to 2009. *J Midwifery Womens Health* 2014;59(1):17-27. doi: 10.1111/jmwh.12172.
22. de Jonge A, Geerts C, van der Goes B, Mol B, Buitendijk S, Nijhuis J. Perinatal mortality and morbidity up to 28 days after birth among 743,070 low-risk planned home and hospital births: a cohort study based on three merged national perinatal databases. *BJOG* 2015;122(5):720-8. doi: 10.1111/1471-0528.13084.
23. Vedam S, et.al. Home birth: an annotated guide to the literature. Univ. British Columbia Website. https://www.birthplacelab.org/homebirth-an-annotated-guide-to-the-literature/ April 2011. Update October 2013. Accessed April 20, 2020
24. American College of Nurse-Midwives. Midwifery provision of home birth services. Clinical Bulletin No.14. *J Midwifery Womens Health*. 2015;61(1):127–133. doi: 10.1111/jmwh.12431
25. American Association of Birth Centers. Standards for birth centers. AABC Website https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/AABC-STANDARDS-RV2017.pdf Approved April 4, 1987. Latest Update October 7, 2017. Accessed April 20, 2020.
26. American Academy of Pediatrics Committee on the Fetus and Newborn. Planned home birth. Policy Statement. *Pediatrics* 2013;131(5):1016-20. Reaffirmed December 2016. doi:10.1542/peds.2013-0575.
27. American College of Nurse-Midwives, Division of Standards and Practice. Planned home birth. Position Statement. ACNM Website. http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000251/Planned-Home-Birth-Dec-2016.pdf Approved December 2005. Update December 2016. Accessed April 20, 2020.
28. American Public Health Association. Increasing Access to out-of-hospital maternity care services through state-regulated and nationally-certified direct-entry midwives. Policy Statement 20013. APHA Website. https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/11/29/increasing-access-to-out-of-hospital-maternity-care-services-through-regulated-direct-entry-midwives Approved January 1, 2001. Accessed April 20, 2020.
29. Association of Women's Health, Obstetric, and Neonatal Nursing. Midwifery. AWHONN Website. https://www.jognn.org/article/S0884-2175(15)30329-4/pdf Approved April 1985. Update January 2009. Accessed April 20, 2020.
30. Coalition for Improving Maternity Services. Mother-friendly childbirth initiative. Improving Birth Coalition Website. http://www.motherfriendly.org/MFCI Approved July 1996. Accessed April 20,2020.
31. National Partnership for Women and Families. Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing. National Advisory Council. NPWF Website. https://www.nationalpartnership.org/our-work/health/reports/maternity-blueprint.html Approved June 2018. Accessed April 20, 2020.

32. Home Birth Consensus Summit. Common ground statements. Home Birth Summit Website. http://www.homebirthsummit.org/summits/vision/statements/ 2011. Accessed April 20, 2020.
33. International Confederation of Midwives. Home birth. Position Statement. ICM Website. https://www.internationalmidwives.org/assets/files/statement-files/2019/06/eng-home-birth14-converted-new-letterhead.pdf Adopted 2005. Revised 2011. Accessed April 20, 2020.
34. Midwives Alliance of North America. Statement of values and ethics. MANA Website https://mana.org/resources/statement-of-values-and-ethics Adopted 1997. Revised 2012. Accessed April 20, 2020.
35. National Institute for Health and Care Excellence. Intrapartum care for healthy women and babies. Clinical Guideline CG190. NICE Website. https://www.nice.org.uk/guidance/cg190 Published December 2014, Updated February 2017. Accessed April 20, 2020.
36. National Perinatal Association. Choice of birth setting. Position Paper. NPA Website. http://nationalperinatal.org/resources/Documents/Position%20Papers/Choice%20of%20Birth%20Setting%20pdf%20.pdf Adopted July 2008. Accessed April 20, 2020.
37. Professional Midwifery Practice Act. New York, USA; 1992. Article 140, Section 6951. NYSED Website. http://www.op.nysed.gov/prof/midwife/article140.htm Effective Nov. 2, 2010. Accessed April 20, 2020.
38. An act to amend the public health law, in relation to midwifery birth centers, §§ 2801-2803 of Public Health Law (2016).
39. New York State Education Department, Office of the Professions. Midwifery--questions and answers. NYSED Website. http://www.op.nysed.gov/prof/midwife/midwifeqa.htm April 7, 2014. Accessed April 20, 2020.
40. New York State Education Department, Office of the Professions. Midwifery. NYSED Website. http://www.op.nysed.gov/prof/midwife/ July 13, 2017. Accessed April 20. 2020.
41. American College of Nurse-Midwives, Midwives Alliance of North America, National Association of Certified Professional Midwives. Supporting healthy and normal physiologic childbirth: a consensus statement. *J Midwifery Womens Health* 2012;57(5):529-32. doi: 10.1111/j.1542-2011.2012.00218.x.
42. Renfrew MJ, Homer CSE, Downe S, et al. Midwifery: An executive summary for The Lancet's Series. The Lancet Website. http://www.thelancet.com/series/midwifery 2014. Accessed April 20. 2020.
43. American College of Nurse-Midwives. Shared decision-making in midwifery care. Position Statement. ACNM Website. https://www.midwife.org/acnm/files/ACNMLibraryData/UPLOADFILENAME/000000000305/Shared-Decision-Making-in-Midwifery-Care-10-13-17.pdf Approved December 2016. Accessed April, 20. 2020.
44. Midwives Association of Washington State. Shared decision making. Position Statement. MAWS Website. https://www.washingtonmidwives.org/position-statements.html Approved April 14, 2008. Accessed April 20. 2020.
45. International Confederation of Midwives. Partnership between women and midwives. Position Statement. ICM Website. https://www.internationalmidwives.org/assets/files/statement-files/2019/06/eng-partnership-between-women-and-midwives1.pdf Adopted 2005. Revised 2011. Accessed April 20, 2020.
46. American College of Obstetricians and Gynecologists, Committee on Ethics. Ethical decision making in obstetrics and gynecology. Committee Opinion No. 390. *Obstet Gynecol* 2007;110(6):1479-87. Reaffirmed 2016. doi: 10.109/01.AOG.0000291573.09193.36.
47. American College of Obstetricians and Gynecologists, Committee on Ethics. Refusal of medically recommended treatment during pregnancy. Committee Opinion No. 664. *Obstet Gynecol* 2016 Jun;127(6):e175-82. doi: 10.1097/AOG.0000000000001485.
48. Rules of the Board of Regents of NY. Part 29. NYSED Website. http://www.op.nysed.gov/title8/part29.htm Effective October 5, 2011. Accessed October 1, 2017.

49. Joseph J. Easy access prenatal clinics. Commonsense Childbirth Website. https://commonsensechildbirth.org/jjway/ April 2009. Accessed April 20, 2020.
50. Alhusen JL, Bower K, Epstein E, Sharps P. Racial discrimination and adverse birth outcomes: an integrative review. *J Midwifery Womens Health* 2016 Nov;61(6):707-720. doi: 10.1111/jmwh.12490.
51. Faucher MA, Collins-Fulea C, Breedlove G. Collaboration in practice: implementing team-based practice: a midwifery perspective. *J Midwifery Womens Health* 2016;61(4):408-10. doi: 10.1111/jmwh.12504.
52. Downe S, Finlayson K, Fleming A. Creating a collaborative culture in maternity care. *J Midwifery Womens Health* 2010;55(3):250-4. doi: 10.1016/j.jmwh.2010.01.004.
53. Sakala C, Corry MP. *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. New York, NY: Milbank Memorial Fund; 2008. NPWF Website. http://www.nationalpartnership.org/research-library/maternal-health/evidence-based-maternity-care.pdf Accessed October 1, 2017.
54. American College of Nurse-Midwives. Collaborative management in midwifery practice for medical, gynecologic and obstetric conditions. Position Statement. ACNM Website https://www.midwife.org/acnm/files/ACNMLibraryData/UPLOADFILENAME/000000000058/Collaborative-Mgmt-in-Midwifery-Practice-Sept-2014.pdf Approved July 27, 1992. Updated September 2014. Accessed April 20, 2020.
55. Vedam S, Leeman L, et al. Transfer from planned home birth to hospital: improving interprofessional collaboration. *J Midwifery Womens Health.* 2014 Nov-Dec;59(6);624-34. doi: 10.1111/jmwh.12251
56. Birth Place Lab. Best practice guidelines for interprofessional collaboration: community midwives and specialist providers. Birth Place Lab Website. https://www.birthplacelab.org/best-practice-guidelines-for-interprofessional-collaboration/ Approved March 2020, Accessed April 20, 2020.
57. Home Birth Consensus Summit. Best practice guidelines: transfer from planned home birth to hospital. Birth Place Lab Website. https://www.birthplacelab.org/best-practice-guidelines-for-transfer-and-collaboration/ Approved April 2014. Updated January 2020. Accessed April 20, 2020.
58. Krueger L. FAQs about the Reproductive Health Act. 2019. Senator Liz Krueger Website. https://www.nysenate.gov/newsroom/articles/2019/liz-krueger/faqs-about-reproductive-health-act Updated February 12, 2019. Accessed April 20, 2020.
59. National Center for Complementary and Integrative Health. Complementary, alternative, or integrative health: what's in a name? National Institutes of Health Website. https://nccih.nih.gov/health/whatiscam Updated June 2016. Accessed April 20, 2020.
60. American College of Nurse-Midwives. Intermittent auscultation for intrapartum fetal heart rate surveillance. Clinical Bulletin No. 13. *J Midwifery Womens Health* 2015;60(5):626-32. doi: 10.1016/j.jmwh.2010.05.007.
61. Collins M. Use of nitrous oxide in maternity care. AWHONN Practice Brief Number 6. JOGNN. 2018;47:239–242; 2018. doi: 10.1016/j.jogn.2018.01.009
62. Emergency Medical Treatment and Active Labor Act. USA; 1986. 42 U.S.C. §1395dd
63. Bovbjerg ML, Cheyney M, Brown J, Cox KJ, Leeman L. Perspectives on risk: assessment of risk profiles and outcomes among women planning community birth in the United States. *Birth* 2017;44(3):209-221. doi: 10.1111/birt.12288.
64. Commission for the Accreditation of Birth Centers. *Indications for compliance with standards for birth centers, Reference addition #1.* 2015. St Paul, MN: CABC.
65. Midwives Association of Washington State. Vaginal birth after cesarean in the out-of-hospital setting. MAWS Website. https://www.washingtonmidwives.org/uploads/1/1/3/8/113879963/maws-vbac-guideline-12.26.12.pdf Approved December 2012. Accessed April 20, 2020.
66. MacDonald T, Saurette K. Management of pre-labor rupture of membranes at term. Clinical Practice Guideline No. 13. Association of Ontario Midwives Website https://www.ontariomidwives.ca/sites/default/files/CPG%20full%20guidelines/CPG-Management-of%20prelabour-rupture-of-membranes-PUB.pdf Adopted July 2010. Updated May 2014. Accessed April 20, 2020.

Resources

For Developing Guidelines

American College of Nurse Midwives. Standards for the practice of midwifery. ACNM Website. http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000051/Standards_for_Practice_of_Midwifery_Sept_2011.pdf Approved March 8, 2003, Latest Updated September 24, 2011. Accessed April 20.

American College of Obstetricians and Gynecologists, Committee on Patient Safety, Quality, and Improvement. Clinical guidelines and standardization of practice to improve outcomes. Committee Opinion No. 792. Website. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/10/clinical-guidelines-and-standardization-of-practice-to-improve-outcomes Approved October 2019. Accessed April 20, 2020.

Brown, CA, Dexter, CA. Clinical practice guideline development and implementation: promoting evidence-based practice for certified professional midwives [master's thesis]. Kenmore, WA. Bastyr University; 2015.

Cook E, Avery M, Frisvold M. Formulating evidence-based guidelines for certified nurse-midwives and certified midwives attending home births. *J Midwifery Womens Health* 2014;59(2):153-9. doi: 10.1111/jmwh.12142.

White Ribbon Alliance. Respectful maternity care: the universal rights of childbearing women. WRA Website. https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf Adopted October 2011. Accessed April, 20 2020.

Institute of Medicine of the National Academies. Clinical practice guidelines we can trust: standards for developing trustworthy clinical practice guidelines(CPGs). National Academies Website. https://www.nap.edu/resource/13058/Clinical-Practice-Guidelines-2011-Report-Brief.pdf Approved March 2011. Accessed April 20, 2020.

For Developing Guidelines for Indications for Consultation, Collaboration and Transfer

AAP and ACOG. *Guidelines for Perinatal Care*, 8th Edition, Appendix B and C. 2017. ISBN: 978-1-934984-67-7 AAP Website. https://reader.aappublications.org/guidelines-for-perinatal-care-8th-edition/2 Approved September 2017. Accessed April 20, 2020.

** College of Midwives of British Columbia. Indications for discussion, consultation and transfer of care. CMBC Website. https://www.divisionsbc.ca/CMSMedia/WebPageRevisions/PageRev-12544/Maternity/Registered%20Midwives%2012.01-Indications-for-Discussion-Consultation-and-Transfer-of-Care.pdf Adopted April 14,1997. Latest Update June 22, 2015. Accessed October 1, 2017.

Guidelines for midwifery care and collaboration when assisting planned home birth. Ithaca, NY: Central and Western NY Home Birth Midwives Consortium; 2014.

Midwives Association of Washington State. Indications for discussion, consultation, and transfer of care in an out-of-hospital midwifery practice. MAWS Website. https://www.washingtonmidwives.org/uploads/1/1/3/8/113879963/maws-indications-2016.pdf Adopted 4-24-2008. Revised December 19, 2016. Accessed April 20, 2020.

National Institute for Health and Care Excellence. *Intrapartum care for healthy women and babies.* Clinical Guideline CG190. NICE Website. https://www.nice.org.uk/guidance/cg190 Published December 2014, Updated February 2017. Accessed April 20, 2020.

Obstetric Working Group. *Obstetric Manual: Final Report of the Obstetric Working Group of the National Health Insurance Board of the Netherlands. The List of Obstetric Indications*. Amstelveen, Netherlands: Royal Dutch Association of Midwives; 1998. Website. http://www.kastanis.org/uploads/0000/0590/Nr.16.OBSTETRIC_MANUAL.pdf Accessed April 20,2020.

New York State Department of Health. Medicaid prenatal care standards. Updated 2015. Available from https://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/ Adopted 1990. Latest Update, October 2019. Accessed April 20, 2020.

Photo Credits: Page 7 -- K Michelle Doyle; Cover and Page 9 – Kate T Finn: Page 11 -- Mario Cassase

This document is a publication of NYSALM, the New York Affiliate of the American College of Nurse-Midwives (ACNM). As such, while it is informed by the policies and positions of ACNM, the document in its entirety does not necessarily represent the positions of the national ACNM organization. For more information about the policies and positions of ACNM, please visit www.midwife.org.

2015 Original Committee
Kate T. Finn, MS LM CM, Chair, Quality Committee, Central NY Regional Representative, Ithaca
Susanrachel Condon, MA LM CNM CCCE LMT, Hudson Valley Representative, Gardiner
K. Michelle Doyle, MSN LM CNM, Secretary, NYSALM, Troy
Evette M. Hernandez, MSN LM CNM, Western NY Representative, Buffalo
Connie Kieltyka, MSN LM CNM, Hudson Valley Representative, Olivebridge
Karen Jefferson, MS LM CM, President, NYSALM, Brooklyn
Rachel Ritter, BA SM, Student Representative, Brooklyn

2017 Revision Committee
Kate T. Finn, MS LM CM, Chair, Quality Committee, Ithaca
Julie Carlson, MSN LM CNM MSW, Central NY Regional Representative, Hamilton
Susanrachel Condon, MA LM CNM CCCE LMT, Hudson Valley Representative, Gardiner
K. Michelle Doyle, MSN LM CNM, Capitol District Representative, Troy
Karen Jefferson, MS LM CM FACNM, President, NYSALM, Brooklyn
Khristeena Kingsley, MS LM CNM, Buffalo
Umaimah Mahmud-Thiam, MS LM CM, Brooklyn

2020 Revision Committee
Kate T. Finn, MS LM CM, Chair, NYSALM Quality Committee,
Vice President, New York Association of Birth Centers (NYABC), Ithaca
K. Michelle Doyle, MSN LM CNM, Troy
Whitney Hall, MA MS LM, CM, Secretary, NYSALM; President, NYABC, Hurley
Dallas Gilpin, Consumer, Treasurer, NYABC, Saugerties
Trinisha Williams, MPH LM CM, FACCE, LCCE, LC, Director of Midwifery, Brooklyn Birthing Center
Executive Board, American Association of Birth Centers

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 to the 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 Community Birth Setting 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 questionnaire and return it to the charge hospital nurse or receiving provider. You may also email your responses to_____.

You may also use this questionaire 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 to the 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

Best Practice Guidelines for Interprofessional Collaboration: Community Midwives and Specialist Providers

Approved March 2020

See Also – Best Practice Guidelines for Transfer from Planned Home Birth to Hospital

Background and Context

Collaborative care throughout the antepartum, intrapartum*, and postpartum periods is crucial to safety in all birth settings, including hospital, birth center, and home. Collaboration improves health outcomes, as well as quality and experience of care. [1,2,3,4] Collaboration between health providers also meets the diverse needs and preferences of families. [5]

Optimal care during the childbearing year depends upon both effective interprofessional collaboration and systems-level support for community-based providers [1,4,6]. Obstetricians, family physicians, nurse- practitioners, and midwives provide care consistent with their education, expertise, and scope of practice. When they work together, they can establish systems to enhance effective communication, role clarity, access to services, and coordination of care across settings. [1] Best Practice Guidelines for Transfer from Planned Home Birth to Hospital as well as Implementation Tools are available and delineate consultation, collaboration, and referral during the intrapartum period. However, most available evidence-based guidelines do not specifically delineate the nature of collaboration and coordination of care between community-based midwives and physicians during the antepartum, postpartum, and newborn phases. Hence, this document, prepared by the multi-disciplinary Home Birth Summit Collaboration Task Force, describes best practices for promoting interprofessional collaboration across community-based and institutional settings for care throughout the childbearing year.

Ethics

Ethical practice honors each person's fundamental rights to access appropriate health education, care and consultation. Ethics statements, as established by all health professions, provide guidance for professional conduct and decision making. Ethical treatment respects a person's autonomy to make informed decisions for themselves and their family, without judgement and in consideration of their belief system and values, including the right to accept or decline treatment options without coercion, threat or fear of abandonment.

In a best practice model, the client/patient, midwife, physician, and family participate in a shared decision-making process, and each provider acts in accordance with ethical standards for all health professions. Coordination of care between healthcare professionals will reflect fairness, honesty, and integrity, and demonstrate mutual respect and concern for the patient/ client. [7]

Equity and Access

The first step toward achieving health equity in childbirth is to ensure that all patients/ clients have access to timely and appropriate care at all stages throughout their pregnancy, birth, and postpartum period. [8] Equity is the quality of being fair, just and impartial without discrimination in regards to race, ethnicity, cultural background, national origin or immigration status, religion, language, sexual orientation or gender expression, health insurance, socio-economic status or difference of belief system or opinion. Putting a focus on reducing barriers to access to care sets an example of health equity that benefits all childbearing families.

For families planning childbirth in a community setting, access to collaboration, consultation and transfer of care is essential to quality, safety, and improved outcomes. [4,5] Strengthening collaborative referral networks also addresses rural maternity care workforce shortages, and improves maternal and newborn health disparities common in rural communities throughout the United States (9,10). Emerging evidence suggests that disparities in health outcomes within communities of color can also be improved through intensive, culturally-competent care in homes, and population-specific community clinics and birth centers. [11]

Vicarious Liability

Midwives' scope of practice and professional responsibility includes consultation, collaboration, and referral to specialist providers, as necessary, to assure quality and safety. In some jurisdictions there are regulatory guidelines for when to initiate consultation. Physicians do not have supervisory relationship with community midwives**.** Hence, individual health care providers working within their own scopes of practice are accountable for their own provision of care, and vicarious liability does not apply.

> *"Vicarious liability refers to the liability of a supervisory party (principal) for the actionable conduct of a subordinate or associate (agent) based on the relationship of the party. Health care providers, including physicians, working in team-based care settings may not always be found to have the requisite principal- agent relationship with other health care team members to be vicariously liable for their actions. In determining legal imputation of vicarious liability, courts will consider the facts of each case, and factors such as statutory and regulatory language in the specific jurisdiction; creation of an agency or employment relationship; and contractual language in the employment, supervisory, or consultative agreement."* [3]

PROVIDER ROLES AND RELATIONSHIPS

Primary Provider in the Childbearing Year

In North America, the primary provider during the childbearing year may be a midwife, family physician, nurse-practitioner, or obstetrician/gynecologist. Primary providers offer preventive and

routine care, including assessment, health promotion and education. If the care needs of the patient/ client extend beyond the area of expertise of the primary provider, they will refer and coordinate care with other specialty providers. Midwives, when they are the primary providers, need to interact with specialists as needs of the client/patient evolve through the childbearing year.

Professional Dialogue (Discussion)

Professional dialogue refers to an informal conversation between providers, a sharing of opinions and knowledge about management of a specific condition or clinical scenario. Generally, this pertains to a clinical question without referencing a particular client/ patient. The primary provider may seek input from a professional peer or from a specialist. The colleague providing input has not examined or talked with the patient/ client or reviewed any medical record. This conversation is not formally documented by either provider. Professional dialogue does not constitute a formal consultation or establish a patient- consultant relationship. [6]

Antepartum, Postpartum, and Newborn Consultation

With the agreement of the patient/client, the midwife, as a primary provider, initiates a consultation upon assessment and identification of need for evaluation by another health care professional. Relevant history, reason for consultation, and medical records accompany the request for consultation. The patient/client has a face-to-face appointment with the specialty provider, although it is also possible to have technology-assisted remote consultation. The consultant may provide a diagnostic evaluation, information, recommendations, therapeutic interventions, or other services. The consultant sends a written summary of their assessment and any recommendations to the midwife. Often, the outcome of a consultation will be that the patient/client remains in the care of the midwife.

Collaboration

Collaboration has been defined as "a process involving mutually beneficial active participation between autonomous individuals whose relationships are governed by negotiated shared norms and visions." Collaborative care is a cooperative, transdisciplinary approach to care when medically indicated or requested by the patient/client. In this model, a midwife and physician coordinate their care for a client/patient or newborn according to their respective scope of practice and skills. [3] Clear and effective communication between the providers about their respective roles and the care plan is essential and clearly documented in the medical record. One health professional takes primary responsibility for ongoing coordination of the collaborative care. The plan occurs in the context of a shared decision-making process that includes the patient/client, midwife, and physician.

Transfer of Care

Transfer of care can happen at any time during the prenatally, intrapartum*, postpartum, or newborn phase. The transfer is typically initiated by the midwife, after a shared decision-making process with theclient/patient that addresses the reason(s) for transfer. A transfer can also be at the request of the patient/client. When care is transferred from a community midwife to a hospital affiliated provider, the referring midwife remains responsible for the patient/client's care, within their own scope of practice, until the receiving provider has seen the patient/client and agreed to assume responsibility for care. If requested by the patient/ client and to facilitate continuity, a referring midwife may participate in communication about the new care plan and continue in a supportive role. [12, 13] Care may be transferred back to the referring midwife, when clinically appropriate. In this situation, the physician remains responsible until the return transfer of care to the midwife has been confirmed by all parties.

Best Practices for the Community Midwife

- Assesses the status of the patient/ client, fetus, or newborn and uses clinical judgment to determine whether discussion, consultation, collaboration, or transfer is indicated.
- Engages with the client/ patient in a process of person-centered decision-making about the assessment and recommendation that consultation, collaboration, or transfer of care is warranted.
- Communicates with the consulting provider, gives a concise verbal and/or written summary of the clinical situation, and provides an assessment of specific care needed, including the degree of urgency.
- Provides contact information and patient/ client records to the office of the consulting provider along with the patient/ client's HIPAA release.
- Documents the consultation, collaboration and transfer in the patient/ client's record.
- Works with the consulting provider and patient/ client to develop a new care plan, including clarifying the continuing role of the midwife.
- Follows up with the client/ patient on any recommendations from the consulting providers and continues to assess status and whether a different level of care is appropriate.
- Provides a summary of the clinical outcome to the consulting provider.
- Maintains confidentiality in communications and when discussing the case with other providers in compliance with relevant HIPAA regulations.

Best Practices for the Collaborating Provider

- Responds to the request for consultation in a timely manner.
- Receives clinical report, verbal or written, from the midwife and reviews the medical record.
- Agrees to make timely appointment with the client/ patient in the office or at the hospital, as appropriate to assess the clinical situation.
- Recommends, orders or performs any necessary diagnostic testing or therapeutic intervention, with client/ patient consent.

- Provides access for the referring midwife to lab, test, and ultrasound results if not available through the midwife's practice.
- Discusses any test results, their assessment, and care recommendations with the patient/ client.
- Respects patient/ client's autonomy and decision making related to recommendations.
- Respects the relationship between the client/ patient and the midwife as the referring provider.
- Sends a written summary of their assessment and recommendations to the primary provider.
- Maintains confidentiality in communications and when discussing the case with other providers in compliance with relevant HIPAA regulations.

Best Practices for Health Systems

When the organization of care ensures integration of midwives across the health system there are demonstrable improvements in maternal, fetal, and newborn health, quality, and safety. [5,14,15,16,17,18,19] Actionable guidelines and policies for collaboration developed by health systems lay a foundation for promoting mutual trust between providers. They also facilitate the patient/ client's acceptance of medical services when consultation, collaboration, or transfer is necessary. The National Academy of Sciences, Engineering and Medicine has delineated best practices to improve coordination of services and access to high quality pregnancy and childbirth care across birth settings. [19]

Person-centered, well-integrated health systems

- Facilitate licensure, regulatory, and institutional credentialing frameworks that support integration of midwives across community and institutional settings.
- Promote and establish systems that support communication, consultation, collaboration, and referral relationships between community midwives and other providers throughout the antepartum, intrapartum, postpartum, and newborn periods of care.
- Facilitate access to procedures and assessments such as ultrasound, lab work, genetic screening or postdates surveillance, and ensure prompt reporting of results to midwife.
- Support presence of midwife during ambulatory encounters if requested by patient/ client.
- Offer clients/ patients planning a community-based birth the opportunity to participate in prenatal/postpartum educational services offered by the system.
- Ensure access for all providers to participate in interdisciplinary protected case review, and remove restrictions to consultation or collaboration due to concerns about vicarious liability.
- Provide opportunities for interprofessional emergency skills training and education that includes midwives, nurses, physicians, and EMS.
- Engage community-based midwives and clients/ patients in quality assurance and improvement initiatives, including development, implementation and evaluation.
- Mandate equitable reimbursement for maternal and newborn services by Medicaid and private insurance companies for all providers, in all settings, including home and birth center.
- Recognize that all primary providers, including midwives, function within their own regulatory frameworks and scopes of practice and do not require or benefit from supervision by another professional.

US Birth Summits, Collaboration Task Force

- Erin A.S. Clark, MD, Associate Professor & Division Director, Maternal-Fetal Medicine, U of Utah
- James Cummings, MD, MS, Clinical Professor Pediatrics and Bioethics, Albany Medical College
- Melissa Denmark, LM, CPM, Licensed Midwife, Smooth Transitions, Snohomish, Washington
- Kate T. Finn, MS, CM, CPM, Licensed Midwife, Homebirth Integration Initiative of New York
- Timothy J. Fisher, MD, MS, Ob/Gyn Residency Program Director, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire
- Lawrence Leeman, MD, MPH, Professor, Family and Community Medicine, Obstetrics and Gynecology, University of New Mexico, Albuquerque, New Mexico
- Audrey Levine, LM, CPM-retired, Licensed Midwife, Smooth Transitions, Olympia, Washington
- Diane Holzer, LM, CPM, PA-C, Fairfax, California
- Tanya Khemet, LM, CNM, Co-President, National Association of Certified Professional Midwives
- Lisa Kane Low, CNM, PhD, FACNM, Professor, Nursing, Obstetrics and Gynecology and Women's Studies, University of Michigan, Ann Arbor, Michigan
- Marian MacDorman, PhD, Professor, Maryland Population Research Center, Univ of Maryland
- Monica R. McLemore RN, MPH, PhD, FAAN, Associate Professor, Family Health Care Nursing Dept, Advancing New Standards in Reproductive Health (ANSIRH), U of California, San Francisco
- Tami J. Michele, DO, FACOOG, Advanced OB/GYN, Grand Rapids, Michigan
- Judy Norsigian, Executive Director, Our Bodies Ourselves, Cambridge Massachusetts
- Cheryl Larry-Osman, Perinatal Clinical Nurse Specialist, Labor & Delivery, High Risk Antepartum, Postpartum, Henry Ford Hospital, Detroit, Michigan
- Tanya Smith-Johnson, MS, Vice-President, Midwives Alliance Hawaii
- Catherine Ruhl, RN, CNM, DNP, Director of Patient Education and Outreach, Association of Women'sHealth, Obstetric, and Neonatal Nurses
- Saraswathi Vedam, PhD, RM, FACNM Sci D(hc), Professor, Division of Midwifery, University of British Columbia, Vancouver, British Columbia

REFERENCES: Best Practice Guidelines for Interprofessional Collaboration: Community Midwives and Specialist Provider

1. Guise, J., & Segel, S. 2008. Teamwork in obstetric critical care. *Best Practice andResearch Clinical Obstetrics and Gynecology*, *22*(5), 937-951.
2. World Health Organization (WHO). 2016. Standards for Improving Quality of Maternal and Newborn Care in Health Facilities [Internet]. Available from: http://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn- care-quality/en/
3. American College of Obstetricians and Gynecologists (ACOG). 2016. Task Force on Collaborative Practice. Collaboration in practice: implementing team-based care / developed under the direction of the Task Force on Collaborative Practice. Washington, DC. Available from: https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group- Reports/Collaboration-in-Practice-Implementing-Team-Based-Care
4. National Institute for Health and Care Excellence (NICE). 2014. Intrapartum care for healthy women and babies. NICE guideline (CG190). Available from: https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and- babies-pdf-35109866447557
5. Healy, S., Humphreys, E., Kennedy, C. 2015. Midwives' and obstetricians' perceptions of risk and its impact on clinical practice and decision making in labour: An integrative review. *Women and Birth.* 30(5): 367-75
6. Vedam S, Stoll K, MacDorman M, Cramer R, Cheyney M, Declercq E, Rubashkin N, Fisher T, Spence R, Butt E, Gaston T. 2018. Mapping midwifery integration across the United States: impact on access, equity, and outcomes. PLOS ONE. Available from: https://doi.org/10.1371/journal.pone.0192523
7. American College of Obstetricians and Gynecologists (ACOG). 2007. Seeking and giving consultation. ACOG Committee Opinion No. 365. *Obstetrics and Gynecology*, 109: 1255–9.
8. Kozhimmannil, K.B., Hardeman, R.R., Henning-Smith C. 2017. Maternity care access, quality and outcomes: a systems-level perspective on research, clinical, and policy needs. *Seminars in Perinatology*, 41 (6), 367-374
9. Nethery E, Gordon W, Bovbjerg ML, Cheyney M. 2018. Rural community birth: maternal and neonatal outcomes for planned community births among rural women in the United States, 2004- 2009. *Birth*, 45 (2):120-129.
10. American College of Obstetricians and Gynecologists (ACOG). 2014. Health disparities in rural women. ACOG Committee Opinion No. 586. *Obstetrics and Gynecology*, 123: 384-8.
11. Day, S. 2014. Exploring The JJ Way: A Model of Care for Reducing Disparities and Improving Perinatal Health. https://pqdtopen.proquest.com/doc/1566193765.html?FMT=ABS
12. Fox, D., Sheehan, A., Homer, C. 2018. Birthplace in Australia: processes and interactions during the intrapartum transfer of women from planned homebirth to hospital. *Midwifery*, 57:18-25.
13. Vedam, S., Leeman, L., Cheyney M., Fisher, T., Myers, S., Low, L., Ruhl, C. 2014. Transfer from planned home birth to hospital: improving interprofessional collaboration. *JMidwifery Women's Health,* 59(6): 624-34.
14. Renfrew MJ, Homer CSE, et al. 2014. Midwifery: an executive summary for *The Lancet*'s series. *Lancet.* 384.
15. Renfrew MJ, McFadden A, Bastos MH, et al. 2014. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *Lancet.* 384: 1129-45.
16. Homer CSE, Friberg IK, Bastos Dias MA, et al. 2014. The projected effect of scaling up midwifery. *Lancet.* 384: 1146-57.
17. Van Lerberghe W, Matthews Z, Achadi E, et al. 2014. Country experience with strengthening of healthy systems and deployment of midwives in countries with high maternal mortality. *Lancet*. 384: 1215-25.
18. ten Hoope-Bender P, de Bernis L, Campbell J, et al. 2014. Improvement of maternal and newborn health through midwifery. *Lancet.* 384: 1226-35.
19. National Academies of Sciences, Engineering, and Medicine. 2020. Birth Settings in America: Improving Outcomes, Quality, Access, and Choice. Washington, DC: The National Academies Press. https://doi.org/10.17226/25636.

APPENDIX C

Best Practice Guidelines:
Transfer from Planned Home Birth to Hospital

Approved April 2014, Updated January 2020
See Also -- Best Practice Guidelines for Interprofessional Collaboration: Community Midwives and Specialist Providers

> *"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 hospitalbased 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:

- To highlight core elements to be included when developing documents and policies related to transfer from home to hospital.
- To promote the highest quality of care for 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] established the legal framework for requiring access to hospital care in the United States. The legal recognition of providers of pregnancy and birth care services varies between states. However, each person seeking care at any point during the childbearing cycle has the right to optimal and respectful care regardless of planned birth setting, who the chosen attendants are, 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 about hospital care and procedures that may be necessary and documents that a plan has been developed with the client/patient for hospital transfer should the need arise. [15]
- The midwife assesses the status of the client/patient, 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 client/patient 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]
- Community based midwives may continue in a primary role as appropriate to their 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 client and family understands the hospital provider's plan of care and the hospital provider understands the pregnant person's need for information regarding care options.
- If the client/patient desires continuity of care with a known provider, the community midwife may remain to provide support or care in accordance with the scope and role within institutional guidelines and available staffing.

Model practices for the hospital provider and staff

- Hospital providers and staff are sensitive to the psychosocial needs of the client/patient 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 client/family. [12]
- Timely access to hospital services and providers may be best accomplished by direct admission to the labor and delivery or pediatric unit. [11-15]
- Whenever possible, the woman/birther and newborn are kept together during the transfer and after admission to the hospital.

- Hospital providers and staff participate in a shared decision-making process to create an ongoing plan of care that incorporates values, beliefs, and preferences of the patient/client.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 client/patient 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. [14]
- Opportunities to debrief the case include all providers and the client/patient/family prior to hospital discharge.

Quality improvement and policy development

Coordination and planning for transfers is best accomplished through development of local standardized procedures. All stakeholders involved in the transfer and 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 process of developing these standardized procedures. Quality improvement processes should incorporate the model practices above and delineate at a minimum the following:

- Communication channels, and amount and type of information needed to alert the hospital to an incoming transfer.
- Provision for notification and assembly of staff rapidly in case of emergency transfer.
- Documentation of the client/patient's perspective regarding 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]

Home Birth Summit, Collaboration Task Force

- Diane Holzer, LM, CPM, PA-C, Fairfax California (Chair)
- Jill Breen, CPM, CLC, Midwife, St. Albans Maine
- Kate T. Finn, MS, CM, CPM, Licensed Midwife, Ithaca New York
- Timothy J. Fisher, MD, MS, FACOG, Chair Department of Surgical Services, Cheshire Medical Center/Dartmouth-Hitchcock Keene, Keene New Hampshire
- Lawrence Leeman, MD, MPH, Professor, Family and Community Medicine, Obstetrics and Gynecology, University of New Mexico, Albuquerque New Mexico
- Audrey Levine, LM, CPM, Licensed Midwife, Olympia Washington
- Ali Lewis, MD, FACOG, OB/GYN, Seattle Washington
- Lisa Kane Low, CNM, PhD, FACNM, Associate Professor, Director Midwifery Education, University of Michigan, Ann Arbor Michigan
- Tami J. Michele, DO, FACOOG, OB/GYN, Fremont Michigan
- Judy Norsigian, Executive Director, Our Bodies Ourselves, Cambridge Massachusetts
- Saraswathi Vedam, PhD, RM, FACNM Sci D(hc), Professor, Division of Midwifery, University of British Columbia, Vancouver British Columbia

REFERENCES -- Best Practice Guidelines: Transfer from Planned Home Birth to Hospital

1. Home Birth Consensus Summit. Collaboration. http://www.homebirthsummit.org/action-groups/collaboration. Accessed November 21, 2013.
2. Cheyney M. Everson C, Burcher P. Homebirth transfers in the United States: narratives of risk, fear and mutual accommodation. *Qual Health Res*. 2014;24(4):443-456.
3. Davis-Floyd R. Home birth emergencies in the U.S. and Mexico: the trouble with transport.
4. *Soc Sci Med*. 2003;56(9):1911-31.
5. Andreatta P, Frankel J, Boblick Smith S, Bullough A, Marzano D. Interdisciplinary team training identifies discrepancies in institutional policies and practices. *Am J Obstet Gynecol*. 2011s;205(4):298-301. doi: 10.1016/j.ajog.2011.02.022.
6. Dadiz R, Guillet R. Interdisciplinary education: improving communication and teamwork for pediatric and obstetric practitioners. *NeoReviews*. 2011;12(2):e63-8.
7. Straub, SD. Implementing best practice safety initiatives to diminish patient harm in a hospital-based family birth center. Newborn Infant Nurs Rev. 2010 ;10;(3):151-6.
8. Cordell MN, Foster TC, Baker ER, Fildes B. Collaborative maternity care: three decades of success at Dartmouth-Hitchcock Medical Center. *Obstet Gynecol Clin North Am*. 2012;39(3):383-98. doi: 10.1016/j.ogc.2012.05.007.
9. Meffe F, Moravac CC, Espin S. An interprofessional education pilot program in maternity care: findings from an exploratory case study of undergraduate students. *J Interprof Care*. 2012;26(3):183-8. doi: 10.3109/13561820.2011.645089.

10. Cornthwaite K, Edwards S, Siassakos D. Reducing risk in maternity by optimising teamwork and leadership: an evidence-based approach to save mothers and babies. *Best Pract Res Clin Obstet Gynaecol.* 201;27(4):571-81. j.bpobgyn.2013.04.004.
11. Association of Women's Health, Obstetric and Neonatal Nurses. *Templates for Protocols and Procedures for Maternity Services.* 3rd edition, Nov. 1, 2012.
12. College of Midwives of Ontario. *Ambulance Act provisions for Patient Transport*. September 16, 2009.
13. Gifford Medical Center, Randolph, VT. *Certified Professional Midwife Relationship Statement*. January 2013.
14. Midwives Association of Washington State -Transport Guideline Committee with the Ad Hoc Physician – Licensed Midwife Workgroup of the State Perinatal Advisory Committee. *Planned Out-Of-Hospital Birth Transport Guideline*. February 2011.
15. New York State Association of Licensed Midwives. *Position Statement on Planned Home Birth in New York*. July 2011.
16. Northern New England Perinatal Quality Improvement Networks, Lebanon, NH. Out of Hospital to In Hospital Perinatal Transfer Form. November 28, 2011.
17. Ontario Medical Association and Association of Ontario Midwives. *Guidelines for Maternal/Neonate Transfers from Home to Hospitals*. February 2005.
18. St. David's Medical Center, Austin, TX. *Midwife Transfer of Care SBAR Tool*. January 2013.
19. The College of Midwives of BC and the Midwives Association of BC. *Implementing Midwifery Services in British Columbia - A Manual for Hospitals and Health Regions*. March 2006.
20. Olsen O, Clausen JA. Planned hospital birth versus planned home birth. *Cochrane Database Syst Rev*. 2012;9:CD000352. doi:10.1002/14651858.CD000352.pub2.
21. de Jonge A, Mesman JA, Manniën J, Zwart JJ, van Dillen J, van Roosmalen J. Severe adverse maternal outcomes among low risk women with planned home versus hospital births in the Netherlands: nationwide cohort study. *BMJ*. 2013;346:f3263.
22. Van der Kooy J, Peoran J, de Graff JP, et al. Planned home compared with planned hospital births in the Netherlands: intrapartum and early neonatal death in low-risk pregnancies. *Am J Obstet Gynecol*. 2011;118(5):1037-46.
23. Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ*. 2011;343:d7400.
24. de Jonge A, van der Goes BY, Ravelli AC, et al. Perinatal mortality and morbidity in a nationwide cohort of 529,688 low-risk planned home and hospital births. *BJOG*. 2009;116(9):1177-84. doi: 10.1111/j.1471-0528.2009.02175.x.
25. Hutton E, Reitsma A, Kaufman, K. Outcomes associated with planned home and planned hospital births in low-risk women attended by midwives in Ontario, Canada, 2003-2006: a retrospective cohort study. *Birth*. 2009;36(3):180-9.
26. Janssen PA, Saxell L, Page LA, Klein MC, Liston RM, Lee SK. Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician. *CMAJ*. 2009;181(6):377-83.
27. Kennare R, Keirse M, Tucker G, Chan A. Planned home and hospital births in South Australia, 1991-2006: differences in outcomes. *Med J Aust*. 2009;192(2):76–80.

28. Cox KJ, Schlegel R, Payne P, Teaf D, Albers L. Outcomes of planned home births attended by certified nurse-midwives in southeastern Pennsylvania, 1983-2008. J *Midwifery Women's Health*. 2013;58(2):145-9.
29. Cheyney M, Bovbjerg M, Everson C, Gordon W, Hannibal D, Vedam S. (2013). Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009. *J Midwifery Women's Health*. 2014;59(1):17-27.
30. L. Planned home births: outcomes among Medicaid women in Washington State. http://www.dshs.wa.gov/pdf/ms/rda/research/7/93.pdf. Published July 1996. Accessed November 21, 2013.
31. Janssen PA, Henderson AD, Vedam S. (2009). The experience of planned home birth: views of the first 500 women. *Birth*. 2009;36(4):297-304. doi:10.1111/j.1523-536X.2009.00357.x.
32. Stramrood CA, Paarlberg KM, Huis In't Veld EM, et al. Posttraumatic stress following childbirth in homelike- and hospital settings. *J Psychosom Obstet Gynaecol.* 2011;32(2):88- 97. doi: 10.3109/0167482X.2011.569801.
33. Johnson KC, Daviss BA. Outcomes of planned home birth with certified professional midwives: large prospective study in North America. *BMJ*. 2005;330:1416.
34. Murphy PA, Fullerton J. Outcomes of intended home births in nurse-midwifery practice: a prospective descriptive study. *Obstet Gynecol.*1998;92(3):461-70.
35. Centers for Medicare & Medicaid Services. Emergency Medical Treatment and Labor Act. http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/ Accessed November 21, 2013.