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# Planned Home Birth in New York State

## New York State Association of Licensed Midwives Guidelines for Best Practice

October 2015

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**New York State Association of Licensed Midwives  
Home Birth Integration Initiative**

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## **Executive Summary:**

The New York State Association of Licensed Midwives (NYSALM) is the professional organization for licensed midwives in New York. NYSALM's mission 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 quality maternal and newborn care. This vision is shared by women, consumer advocates, obstetrical consultants, and other members of the health care team. Midwifery practice for women who choose planned home birth (PHB) upholds these goals.

In keeping with its mission, NYSALM has developed a series of documents for midwives to use which highlight best practice when caring for women who choose childbirth in the home setting. The four documents coordinate to meet the following objectives:

1. Describe background information and context of PHB in New York State
2. Outline elements of routine prenatal, intrapartum, postpartum and newborn care provided by midwives for essentially healthy women and newborns for PHB
3. Define collaborative relationships for midwives attending PHB, the process midwives use to facilitate consultation, collaboration and referral (CCR), and outline indications for which CCR is recommended
4. Adopt national best practice guidelines optimizing care during transfers from a PHB to a hospital

Additionally, articulating these approaches for quality care for PHB will help educate consumers about recommended practice. Midwives in NY are independent providers for complete routine care. Consumers will be informed that midwives facilitate a team approach for accessing advanced care and facilitate putting women 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 and their infants when advanced care is indicated. Planned home birth is recognized to have the best outcomes when practiced within a maternity system that integrates and coordinates with midwives to meet the needs of women who make this choice.<sup>1</sup>

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

## **Document Development Process:**

A committee of seven midwives, who are also board members of NYSALM, undertook weekly meetings for over a year to update the 2010 NYSALM Planned Home Birth Statement. Work started with an analysis of existing barriers to integration of PHB within the maternity care system.

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

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

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

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 CCR. Saturation was expected with inclusion criteria when sources were limited to US and international jurisdictions with regulated midwifery practice, where published studies demonstrated safety or cost effectiveness of PHB practice. These include guidelines from organizations in Washington State, the Netherlands, the United Kingdom, and British Columbia, Canada. It was also deemed appropriate to include indications for CCR from Upstate NY Home Birth Midwives Consortium, and the ACOG/AAP Guidelines for Perinatal Care.

*Guidelines for Indications for Consultation, Collaboration and Referral* was formulated from tabulation of the regional exemplar indications for CCR in an Excel spreadsheet. 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 (small box)
3. Conditions recommended for consultation, collaboration or referral in which the woman, midwife and consultant jointly develop the individualized care plan (large box)

*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 NY Midwifery Practice Act.

After the committee prepared the document, the draft was circulated for structured review to stakeholders from 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.

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](http://www.midwife.org).

These documents reflect practice as of the date issued, which may be subject to change. It is expected the document will be released for a trial period by New York midwives, not to exceed two years. Thereafter, structured feedback from similar stakeholders who have used the document will be solicited to engender revisions. Planned Review: 2017

## Contents

1. Overview of Midwifery Practice for Planned Home Birth  
*Informational description of midwifery practice for planned home birth in New York State*
2. Routine Midwifery Care when Facilitating Planned Home Birth  
*Informational outline of the scope and content of midwifery care for essentially healthy women and newborns when attending a planned home birth*
3. Guidelines for Consultation, Collaboration and Referral for Planned Home Birth  
*Professional guidelines for midwifery practice describing the process and indications for consultation, collaboration and referral with specialty provider, whereby the woman, midwife, and consultant jointly develop an individualized care plan that promotes optimal health for the woman and newborn*
4. Home Birth Summit Best Practice Guidelines: Transfer from Planned Home Birth to Hospital  
*National guidelines adopted from the Home Birth Summit facilitate highest quality care during transfer from planned home birth to the hospital*
5. Clinical Record Summary for Transfer from Planned Home Birth to Hospital  
*Cover sheet in SBAR format recommended to accompany the medical record, summarizing clinical details for coordinating communication during transfer*
6. References and Resources

# Midwifery Practice for Planned Home Birth

## **Women choose to birth at home for quality of care.**

Quality of care indicators such as support for physiologic birth,<sup>2</sup> lower intervention rates, continuity of provider, and the ability to personalize care lead many women to experience high levels of satisfaction. These hallmarks of midwifery practice also enhance safety, and are among the primary reasons women choose to birth at home.<sup>3</sup>

## **The benefits of planned home birth with qualified midwives are supported by best evidence.**

The best quality studies for examining the safety of planned home birth (PHB) must meet specific criteria.<sup>4</sup> Quality studies that seek to evaluate PHB as practiced in New York State must exclude unintended out-of-hospital birth from the PHB cohort; participants must be those who receive complete maternity care from qualified licensed providers with legal access to appropriate safety equipment; and candidates must have ready access to consultation within the maternity care system when higher level care is indicated.

When these specific circumstances are met, studies of PHB show excellent outcomes and very low rates of intervention.<sup>5,6</sup> Such studies show lower rates of induction or augmentation, epidural anesthesia, operative vaginal delivery, cesarean section, and episiotomies.<sup>6-8</sup> Infants born at home have lower incidence of resuscitation. Rates of perinatal death are very low and are comparable to those in hospital births.<sup>7,9</sup> An annotated literature review related to planned home birth is regularly updated.<sup>5</sup> Additional review of the evidence is described in the ACNM clinical bulletin *Midwifery Provision of Home Birth Services*.<sup>10</sup>

## **Women's right to choose planned home birth has overwhelming health policy support.**

International and national maternal-child health organizations focus on supporting best quality services when women plan home births. Such organizations include, but are not limited to:

American Association of Pediatricians (AAP)<sup>11</sup>

American College of Nurse-Midwives (ACNM)<sup>10</sup>

American College of Obstetricians and Gynecologists (ACOG)<sup>1</sup>

American Public Health Association (APHA)<sup>12</sup>

Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)<sup>13</sup>

Coalition for Improving Maternity Services (CIMS)<sup>14</sup>

Childbirth Connection / National Partnership for Women and Families<sup>15</sup>

Home Birth Summit (HBS)<sup>16</sup>

International Confederation of Midwives (ICM)<sup>17</sup>

Midwives Alliance of North America (MANA)<sup>18</sup>

National Institute for Health and Care Excellence (NICE)<sup>19</sup>

National Perinatal Association (NPA)<sup>20</sup>

World Health Organization (WHO)<sup>21</sup>

## **Midwives licensed by New York State are recognized as qualified planned home birth providers.**

Licensed Midwives (LM) are recognized as 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."<sup>22</sup>

Licensed midwives “practice in a wide variety of settings including hospitals, clinics, birth centers, clients’ homes, and private professional offices.”<sup>23</sup> 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.<sup>24</sup>

**Midwives create a culture of safety by providing comprehensive care.**

Monitoring the well-being of women and infants throughout the childbearing cycle is integral to midwifery care. In New York, model midwifery practice incorporates *NYSALM Routine Midwifery Care when Facilitating Planned Home Birth*. Midwives provide comprehensive prenatal care, including ordering ultrasounds, laboratory and genetic testing. Midwives deliver hands-on clinical care and monitoring during active labor and birth. Women and newborns receive continuity of clinical care and breastfeeding support from their midwives during the postpartum period. Care is focused on evidence-based, physiologic principles.<sup>25</sup> Clinically appropriate interventions and emergency measures are used when indicated.

**Midwives use ongoing screening to promote healthy outcomes for mothers and babies.**

In New York State, model midwifery practice utilizes *NYSALM Guidelines for Consultation, Collaboration and Referral for Planned Home Birth*. The guidelines set forth in this document, along with the midwife’s clinical judgment, are utilized for assessing which clients are good candidates for a PHB, as well as for providing ongoing care. The best candidates are women who are essentially healthy with a full-term, singleton fetus in cephalic presentation. These women and their partners also demonstrate the knowledge, capacity, and judgment to choose PHB and to adapt to the changeable nature of pregnancy, labor, and birth for both mother and newborn.

**Midwives facilitate quality care by engaging in a shared decision-making process with clients.**

Quality maternal and newborn care places the woman at the center of the care process.<sup>26</sup> The woman is understood to be the decision maker for herself and her fetus or newborn. She considers her own experiences, values, and cultural perspectives, and assesses the benefits expected from having her baby at home, as well as her individual risks. A pregnant woman’s right to bodily integrity and self-determination is intrinsic to the midwifery and medical professions, and is a foundational principle within organizations responsible for promoting quality maternity care.<sup>10, 18, 26-30</sup> Shared decision-making grows out of the ethical principle of autonomy. Greater patient involvement in care generally results in better health outcomes and higher levels of patient satisfaction.<sup>26</sup> Midwives engage women and their families in shared decision-making to promote individualization of care within the context of midwifery scope of practice. Professional midwifery practice and women’s desires are typically aligned. Therefore, midwives honor the decisions of women in their care 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.<sup>31</sup>
- Clients demonstrate understanding and willingness to accept responsibility for the potential risks and results of their decisions.

**Midwives have collaborative relationships with physicians and transport to hospitals when higher level care is indicated.**

The evidence for quality PHB services highlights the responsibility of the midwife and local perinatal system to coordinate communication and collaboration to achieve optimal outcomes. As primary care providers, midwives provide on-going screening for women and newborns in their care. When conditions arise that warrant advanced care, midwives facilitate the appropriate consultation, collaboration, or referral (CCR) according to the guidelines set forth in the documents *NYSALM Guidelines for Consultation, Collaboration and Referral* and the *HBS Best Practice Guidelines: Transfer from Planned Home Birth to Hospital*.<sup>15, 32-34</sup>

**Summary**

Physicians and midwives have a long history of working together for the improvement of maternal and newborn health. The best available evidence and public health policy recommendations support planned home birth as a reasonable option for women and families who seek a physiologic birth. The highest quality of care occurs with inter-professional coordination across care settings.



# Routine Midwifery Care Facilitating Planned Home Birth

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

## Midwifery Care

- Evaluating subjective and objective data to formulate assessments/diagnoses, and developing, implementing, and modifying plan of care, documenting course of care
- Providing health education and facilitating client-centered shared decision-making
- Promoting physiological wellness and utilizing technological interventions as indicated
- Arranging for physician consultation, collaboration, or referral, 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 Maternal/Fetal Assessment: dating, weight, BP, fundal height, fetal heart rate, fetal lie, presentation, and position
  - Health Education: wellness, nutrition, exercise, parenting, vaccinations, HIV and prenatal testing options, advance directives
  - Childbirth Preparation: physiologic birth principles, home birth supplies, home visit
  - Contingency Planning: emergency plan, transfer procedures, medical treatments used at home and in hospitals
  - Community Resources and Referrals: genetic counseling, social services, psychotherapy, complementary health providers<sup>35</sup>

## Intrapartum Care

- Licensed Midwife and assistant on call 24/7; Licensed Midwife present during active labor
- Maternal Monitoring: labor history, physical examination, vital signs, contractions, membrane status, emotional support
- Fetal Monitoring: presentation and position, movements, intermittent FHR auscultation<sup>36</sup>
- Supportive Care:
  - Ambulation: walking and position changes
  - Intake and Output: water, caloric fluids, light foods, voiding, vomiting
  - Physical/Emotional Support: hands-on presence, reassurance, massage, hydrotherapy, transcutaneous electrical nerve stimulation, etc.
  - Facilitating Birth: promoting physiologic labor and birth, protecting the perineum
  - Facilitating Newborn Transition: Apgar, respiration, thermoregulation, sterile cord clamping
- Management and Interventions, as indicated, during birth and postpartum periods:
  - Vaginal exams, amniotomy, urinary catheterization, nipple stimulation, episiotomy, IV fluids, GBS prophylaxis, oxytocic agents in third or fourth stages, newborn suctioning, oxygen administration, PPV, CPR, manual placental removal, repair of laceration or episiotomy, complementary health approaches,<sup>35</sup> among others

**Immediate Postpartum Care**

- Maternal Monitoring/Care: vital signs, fundus, lochia, estimated blood loss, breastfeeding and bonding, ambulation, urination, food intake, showering and self-care
- Newborn Monitoring/Care: vital signs, weight and measurements, breastfeeding 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, breastfeeding
- Mother and newborn will remain under care until stabilized

**Follow-up Postpartum Care**

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

**Quality Assurance**

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

## Guidelines for Consultation, Collaboration and Referral for Planned Home Birth (CCR)

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

**In accord with the NY Midwifery Practice Act, midwives maintain collaborative relationships with obstetrical physicians.**<sup>22</sup> 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 maternity and newborn hospital facilities. During the prenatal period, the midwife works with every client to develop a home-to-hospital transfer plan that is recorded in the client's medical record. Clients may seek medical consultation at any time for any reason. Appropriate records of prior midwifery care are made available. Documentation of CCR is made in the client's record.

New York State midwives define CCR for planned home birth as follows:<sup>37</sup>

**Consultation** is the process whereby a midwife, who maintains primary management responsibility for the woman's care, seeks the advice or opinion of a physician or another member of the health care team.

**Collaboration** is the process whereby a midwife and physician jointly manage the care of a woman or newborn when medically indicated. Effective communication between the midwife and physician 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.

**Referral** is the process whereby the midwife directs the woman to a physician or another healthcare professional for management of a particular condition or aspect of care.

Midwives and the families within their care expect to engage with a maternity care system and providers who are focused on respectful, quality care. The federal Emergency Medical Treatment and Labor Act<sup>38</sup> requires that a pregnant woman in labor will receive assessment and stabilizing care at the referral hospital. The national *Home Birth Summit Best Practice Guidelines: Transfer from Planned Home Birth to Hospital*, adopted into this document, provides the standards for establishing coordination, communication, and care between midwives attending women planning childbirth at home, and physicians, midwives and hospital staff who receive referrals.

**CCR is indicated for any woman with significant medical or psychological conditions that may impact perinatal health.**

The following indications serve as professional guidelines for CCR in the context of planned home birth. The midwife implements timely consultation, collaboration, referral, and transport to a hospital in accordance with the midwife's clinical judgment and locally available resources.

### Examples of Indications Recommended for Intrapartum Hospital Care

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

## Additional Indications for CCR

### 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 drug abuse  
Current smoking  
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  
Confirmed 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<sup>39</sup>  
Evidence of chorioamnionitis or infection  
Active genital herpes  
Suspected uterine rupture  
Prolapsed umbilical cord  
Thick particulate meconium  
Unresolved fetal heart rate abnormalities  
Fetal demise  
Mother's request for pain medication or hospitalization

### Postpartum Conditions

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

### Newborn Conditions

Apgar < 7 at 5 min  
Unresolved respiratory distress  
Use of extensive resuscitative measures  
Central cyanosis  
Persistent temperature instability  
Persistent 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  
Significant congenital anomalies  
Abnormal blood clotting  
Suspected infection

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

*This section reprinted from the national Home Birth Summit.  
www.homebirthsummit.org*

“We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes. All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. When ongoing inter-professional dialogue and cooperation occur, everyone benefits.”<sup>40</sup>

The statement above from the Home Birth Consensus Summit serves as the foundation for the following guidelines on transfer from planned home birth to hospital. These guidelines were developed by a multidisciplinary group of home and hospital based providers and stakeholders who were delegates at the national Home Birth Consensus Summits in 2011 and 2013. These guidelines are informed by the best available evidence on risk reduction and quality improvement and by existing regional policy and practice documents addressing transfer from home to hospital.<sup>2, 11, 41-57</sup>

The purpose of these guidelines is twofold:

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

When indicated, access to 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.<sup>7, 8, 58-70</sup>

State-specific hospital regulations and the Emergency Medical Treatment and Labor Act (EMTALA)<sup>38</sup> establish the legal framework for requiring access to hospital care in the United States. The legal recognition of providers of maternity care services varies between states. However, each woman seeking care at any point during the maternity cycle has the right to optimal and respectful care regardless of her planned birth setting, the persons she selects to be part of the process, or state provider regulations.

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

## **Model practices for the midwife**

- In the prenatal period, the midwife provides information to the woman about hospital care and procedures that may be necessary and documents that a plan has been developed with the woman for hospital transfer should the need arise.<sup>57</sup>
- The midwife assesses the status of the woman, fetus, and newborn throughout the maternity care cycle to determine if a transfer will be necessary.

- The midwife notifies the receiving provider or hospital of the incoming transfer, reason for transfer, brief relevant clinical history, planned mode of transport, and expected time of arrival.<sup>49, 51-53, 56, 57</sup>
- The midwife continues to provide routine or urgent care en route in coordination with any emergency services personnel and addresses the psychosocial needs of the woman during the change of birth setting.
- Upon arrival at the hospital, the midwife provides a verbal report, including details on current health status and need for urgent care. The midwife also provides a legible copy of relevant prenatal and labor medical records.<sup>49, 50, 53, 56, 57</sup>
- The midwife may continue in a primary role as appropriate to her scope of practice and privileges at the hospital. Otherwise the midwife transfers clinical responsibility to the hospital provider.<sup>51</sup>
- The midwife promotes good communication by ensuring that the woman understands the hospital provider's plan of care and the hospital provider understands the woman's need for information regarding care options.
- If the woman chooses, the midwife may remain to provide continuity and support.

### **Model practices for the hospital provider and staff**

- Hospital providers and staff are sensitive to the psychosocial needs of the woman that result from the change of birth setting.<sup>49</sup>
- Hospital providers and staff communicate directly with the midwife to obtain clinical information in addition to the information provided by the woman.<sup>50</sup>
- Timely access to maternity and newborn care providers may be best accomplished by direct admission to the labor and delivery or pediatric unit.<sup>49-52, 57</sup>
- Whenever possible, the woman and her newborn are kept together during the transfer and after admission to the hospital.
- Hospital providers and staff participate in a shared decision-making process with the woman to create an ongoing plan of care that incorporates the values, beliefs, and preferences of the woman.
- If the woman chooses, hospital personnel will accommodate the presence of the midwife as well as the woman's primary support person during assessments and procedures.
- The hospital provider and the midwife coordinate follow up care for the woman and newborn, and care may revert to the midwife upon discharge.
- Relevant medical records, such as a discharge summary, are sent to the referring midwife.<sup>52</sup>

### **Quality improvement and policy development**

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

- Communication channels and information needed to alert the hospital to an incoming transfer.
- Provision for notification and assembly of staff rapidly in case of emergency transfer.
- Opportunities to debrief the case with providers and with the woman prior to hospital discharge.
- Documentation of the woman's perspective regarding her care during transfer.
- A defined process to regularly review transfers that includes all stakeholders with a shared goal of quality improvement and safety. This process should be protected without risk of discovery.<sup>50</sup>
- 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.<sup>11, 41-48</sup>

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## Summary of Record for Transfer from Planned Home Birth to Hospital

<p><b>SITUATION</b></p> <p>Mother's Name _____</p> <p>DOB _____ Age _____</p> <p>G _____ P _____ EGA _____ EDD _____</p> <p><input type="checkbox"/> Transfer Mother -- Stage _____</p> <p><input type="checkbox"/> Transfer Newborn -- Age _____</p> <p>Reason for Transfer _____</p> <p>Transfer Via: <input type="checkbox"/> Car <input type="checkbox"/> EMS ETA _____ <input type="checkbox"/> Urgent</p> <p>Request Admit: <input type="checkbox"/> LD <input type="checkbox"/> OR <input type="checkbox"/> NICU <input type="checkbox"/> Provider to ED</p> <p>Midwife _____</p> <p>Phone Contact _____</p>	<p><b>TRANSFER RECORD</b></p> <p>Date _____ Time of Call _____ Call Made by _____</p> <p>Receiving Hospital _____</p> <p>Hospital Staff Receiving Call _____</p> <p>Receiving Provider _____</p> <p>Other Receiving Hospital Staff _____</p> <p><input type="checkbox"/> Transfer by Private Car: Time Departed Home _____</p> <p><input type="checkbox"/> Transfer by EMS: Called _____ Arrived _____ Departed _____</p> <p>EMS Staff _____</p> <p>Time: Arrival at Hospital Door _____ L&amp;D Room _____</p> <p>Time: Receiving Provider Present _____ Verbal Report _____</p> <p>Medical Records provided, #pages _____ <input type="checkbox"/> Records at Hospital</p>
<p><b>BACKGROUND – Medical and Antenatal History as Relevant</b></p> <p>Significant Medical History _____</p> <p>Medications/Supplements _____ Allergies _____</p> <p>Prior Pregnancy Outcomes _____</p> <p>Significant Prenatal History _____</p> <p>Baseline BP _____ Ultrasound _____</p> <p>Lab Review: Type/Rh _____ Hg or Hct _____ RPR _____ HIV _____ HBSAg _____ Rubella _____ GBS _____ (date _____)</p> <p>Glucose _____ Fetal Screen _____</p> <p>Other: _____</p>	
<p><b>BACKGROUND – Labor History -- Date and Time</b></p> <p>Latent Labor Onset _____ Duration _____</p> <p>Active Labor Onset _____ Duration _____</p> <p>Second Stage Onset _____ Duration _____</p> <p>Birth _____</p> <p>Membranes ROM _____ Duration _____</p> <p>Placenta Delivered _____ Duration _____</p> <p>Other: _____</p>	<p><b>BACKGROUND -- Most Recent Physical Findings</b></p> <p>Last VS: Time _____ BP _____ P _____ T _____ R _____</p> <p>Contraction Pattern _____</p> <p>Cervix Exam: Time _____ cm _____ % _____ soft / firm</p> <p>Fetus: Station _____ Position _____ Caput _____</p> <p>Fetal Heart: Time _____ FHR _____</p> <p>Membranes: <input type="checkbox"/> Intact <input type="checkbox"/> SROM <input type="checkbox"/> AROM <input type="checkbox"/> Color _____</p> <p>Placenta Intact: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Est Blood Loss _____</p> <p>Perineum: <input type="checkbox"/> Intact <input type="checkbox"/> Episiotomy <input type="checkbox"/> Laceration _____</p> <p>Other: _____</p>
<p><b>BACKGROUND – Maternal Procedures</b></p> <p>IV: Time _____ Volume _____ Cannula Size _____</p> <p>GBS: Antibiotic _____</p> <p>Times/Doses _____</p> <p>Hemorrhage: _____</p> <p>Medications _____</p> <p>Procedures _____</p> <p>Sutures: _____</p> <p>Other: _____</p>	<p><b>BACKGROUND – NEWBORN</b> <input type="checkbox"/> NA: Not Transferred (with Mother)</p> <p>Name _____ <input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p>Apgar: 1 min _____ 5 min _____ 10 min _____ Birth Weight _____</p> <p>Last VS: Time _____ Heart Rate _____ Resp Rate _____ Temp _____</p> <p>Feeding _____ Time Last Feed _____</p> <p>Resusc: <input type="checkbox"/> Suction <input type="checkbox"/> O2 <input type="checkbox"/> PPV <input type="checkbox"/> Chest Comp. <input type="checkbox"/> SPO2 _____</p> <p><input type="checkbox"/> Vitamin K _____ <input type="checkbox"/> Eye Tx <input type="checkbox"/> Blood Glucose _____</p> <p><input type="checkbox"/> Metabolic Screening <input type="checkbox"/> CCHD Screen <input type="checkbox"/> Jaundice _____</p> <p>Other: _____</p>
<p><b>ASSESSMENT—MATERNAL</b></p> <p>_____</p>	<p><b>ASSESSMENT – NEWBORN</b></p> <p>_____</p>
<p><b>RECOMMENDATIONS FOR CARE</b> (Care and personnel likely needed upon arrival.)</p> <p>_____</p>	

Completed By \_\_\_\_\_ Title \_\_\_\_\_ Date/Time \_\_\_\_\_



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### For Developing Guidelines for Indications for Consultation, Collaboration and Referral from PHB

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