Home Birth Summit

The Future of Home Birth in the United States: Addressing Shared Responsibility

Best Practice Guidelines:
Transfer from Planned Home Birth to Hospital

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

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

The purpose of these guidelines is twofold:

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

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

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

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

Model practices for the midwife

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

Model practices for the hospital provider and staff

- Hospital providers and staff are sensitive to the psychosocial needs of the woman that result from the change of birth setting. [11]
- Hospital providers and staff communicate directly with the midwife to obtain clinical information in addition to the information provided by the woman. [12]
- Timely access to maternity and newborn care providers may be best accomplished by direct admission to the labor and delivery or pediatric unit. [11-15]
- Whenever possible, the woman and her newborn are kept together during the transfer and after admission to the hospital.
- Hospital providers and staff participate in a shared decision-making process with the woman to create an ongoing plan of care that incorporates the values, beliefs, and preferences of the woman.
- If the woman chooses, hospital personnel will accommodate the presence of the midwife as well as the woman's primary support person during assessments and procedures.
- The hospital provider and the midwife coordinate follow up care for the woman and newborn, and care may revert to the midwife upon discharge.
- Relevant medical records, such as a discharge summary, are sent to the referring midwife. [14]

Quality improvement and policy development

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

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

Quality of care is improved when policies and procedures are in place to govern best practices for coordination and communication during the process of transfer or transport from a home or birth center to a hospital.[2-10]

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
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- Judy Norsigian, Executive Director, Our Bodies Ourselves, Cambridge Massachusetts
- Saraswathi Vedam, RM, MSN, FACNM Sci D(hc), Professor, Division of Midwifery, University of British Columbia, Vancouver British Columbia

REFERENCES

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. *Soc Sci Med.* 2003;56(9):1911-31.
4. 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.
5. Dadiz R, Guillet R. Interdisciplinary education: improving communication and teamwork for pediatric and obstetric practitioners. *NeoReviews.* 2011;12(2):e63-8. doi: 10.1542/neo.12-2-e63.
6. 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.
7. 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.
8. 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.
9. 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. doi: 10.1016/j.bpobgyn.2013.04.004.
10. American Academy of Pediatrics. Planned home birth. Policy statement. *Pediatrics.* Published online April 29, 2013. doi:10.1542/peds.2013-0575.
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 Hospital.* 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. Cawthon 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.

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Best Practice Transfer Guidelines

Home Birth Summit Collaboration Task Force

2014

Home Birth Consensus Summit

Organizational Representation for Planning

Home Birth Consensus Summit

- October 20-22, 2011
- Warrenton, VA

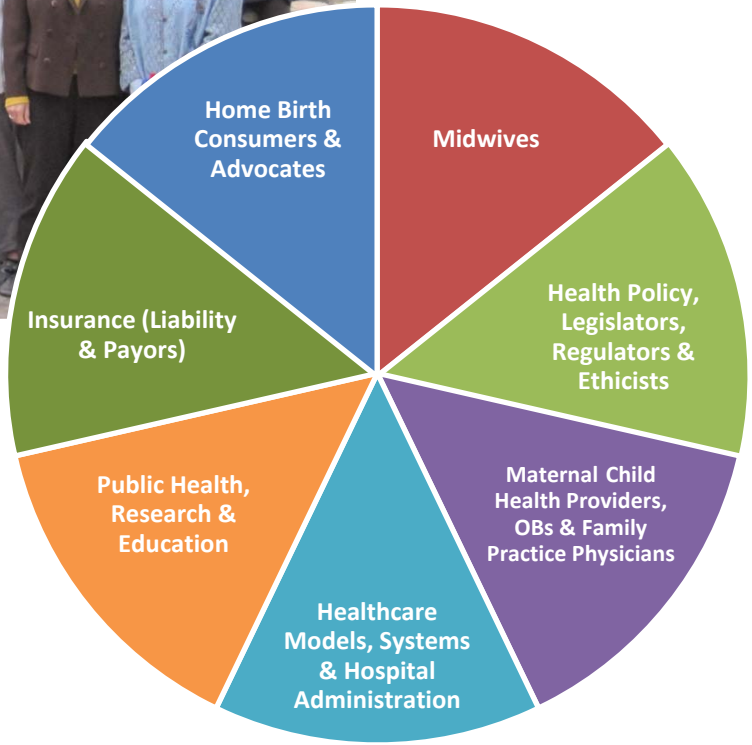
National leaders from all stakeholder perspectives in maternity services met to address shared responsibility for care across birth settings in the United States.

Home Birth Consensus Summit

Improved integration of services across birth sites for all women and families in the U.S.

- *A cross-section of the maternity care system in one room*
- *A shared passion for quality in maternity care*
- *A commitment to work together to improve safety for women and babies across birth sites*
- *All perspectives and viewpoints considered*
- *Purposeful dialogue*

Stakeholder groups representing the complete spectrum of maternity care:



What did we do?

- The Future Search Model, known for achieving cooperative action in highly polarized issues, facilitated the group in discovering common ground

Visioning in Stakeholder Groups

Visioning in Mixed Groups

The "Elephant"

Did not debate home birth as:

-Right or Wrong

-Safety or Harm

-Agree or Disagree

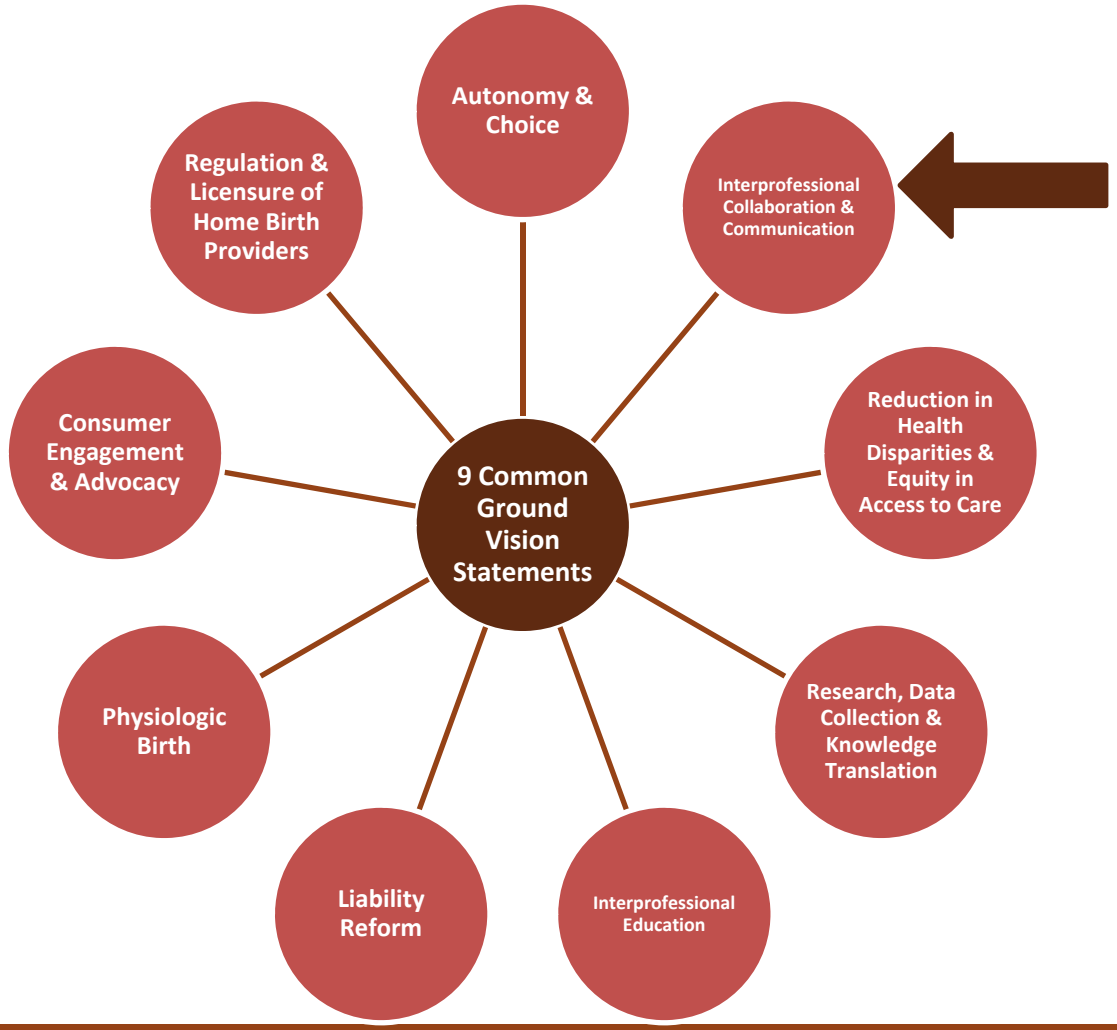
All participants agreed on the need to improve care.

Summit Outcomes

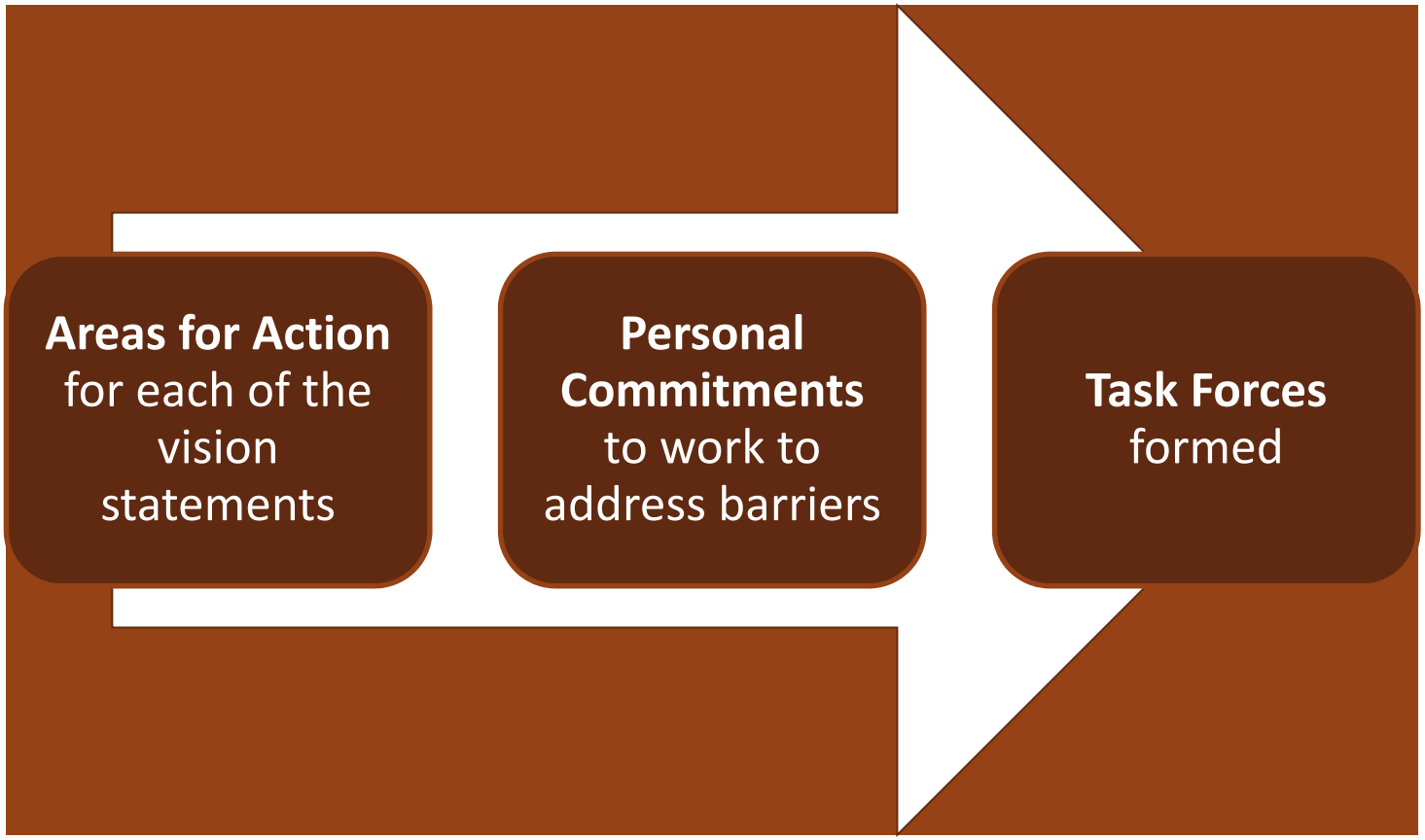
Our 3 days of labor resulted in the birth of:

- *9 Common Ground Statements*
- *Task Force Groups*

Outcomes


Autonomy & Choice
Regulation & Licensure of Home Birth Providers
Interprofessional Collaboration & Communication
Consumer Engagement & Advocacy
9 Common Ground Vision Statements
Reduction in Health Disparities & Equity in Access to Care
Physiologic Birth
Research, Data Collection & Knowledge Translation
Liability Reform
Interprofessional Education

Outcomes


Areas for Action for each of the vision statements
Personal Commitments to work to address barriers
Task Forces formed

Vision

Interprofessional Collaboration & Communication

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When ongoing inter-professional dialogue and cooperation occur, everyone benefits."

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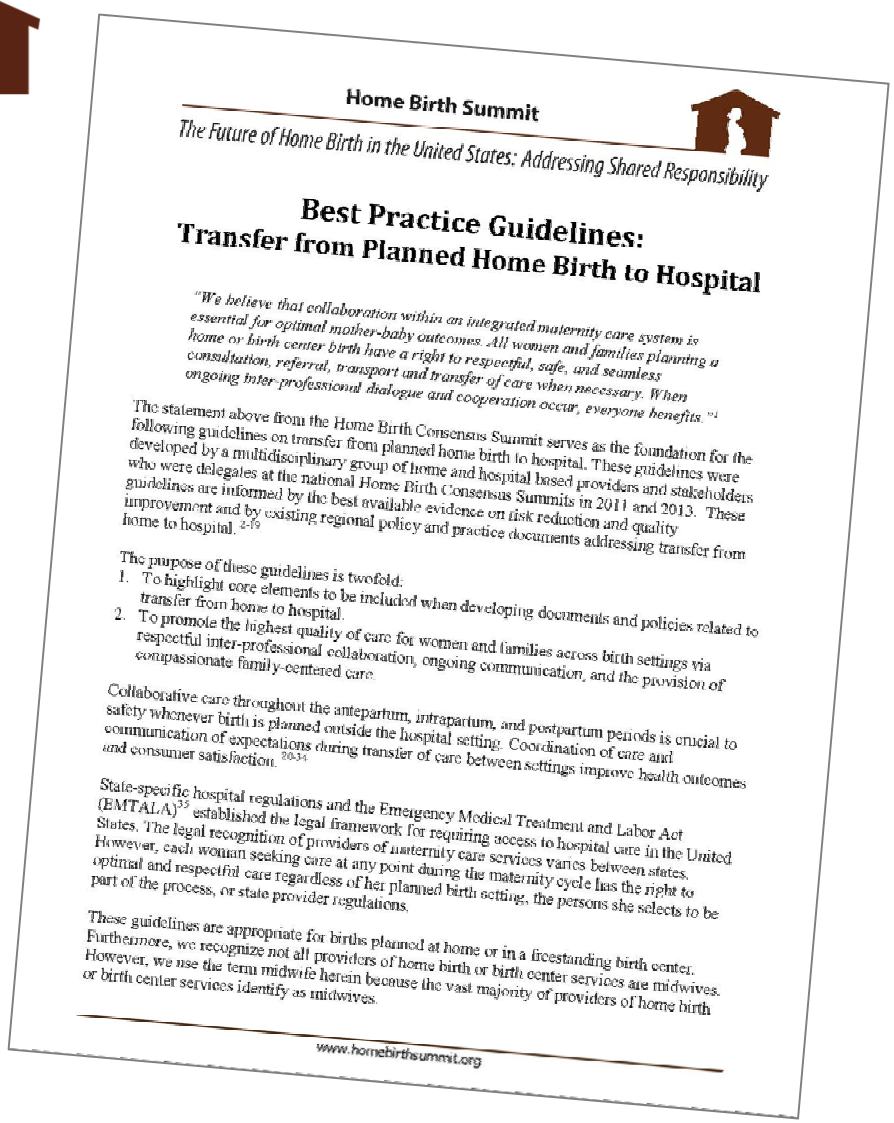
a unique collaboration among physicians, midwives, nurses and consumers



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Best Practice Guidelines: Transfer from Planned Home Birth to Hospital

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The purpose of these guidelines is twofold:

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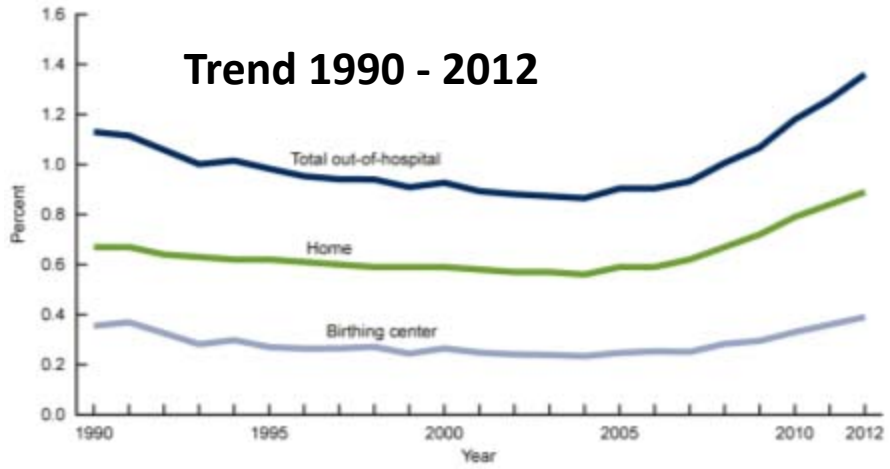
www.homebirthsummit.org

Why is this needed?

Increasing Numbers of Home and Birth Center Births

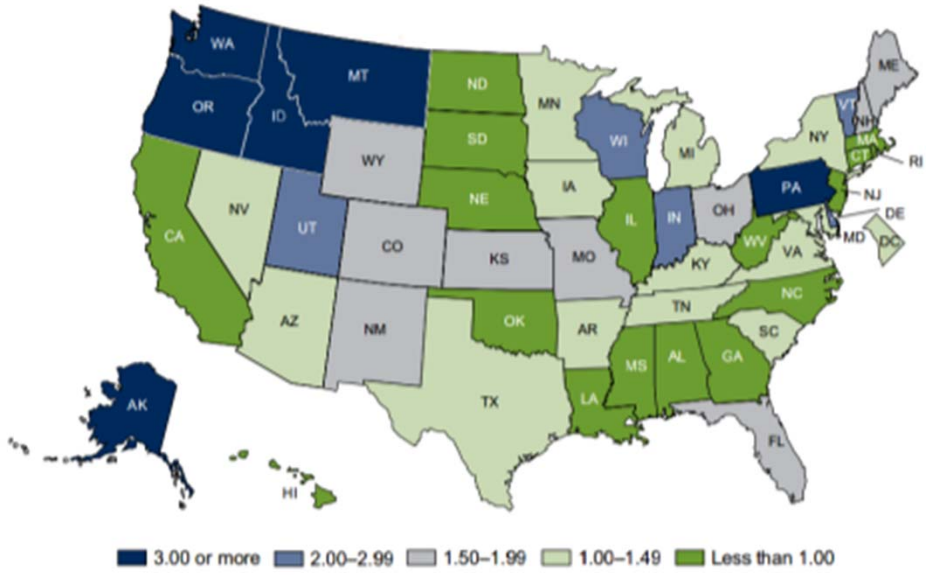


2012 Total

1.36% Nationwide

2-6.0% 11 states

Percentage of births by state: 2012



8-12% • Planned home birth or birth center **transfer rate** to hospital after onset of labor

78% • The majority of transfers are for non-urgent reasons, such as failure to progress in labor for primiparas

Source: CDC/NCHS: Trends in Out-of-Hospital Births in the United States, 1990-2012

Key Findings from CDC

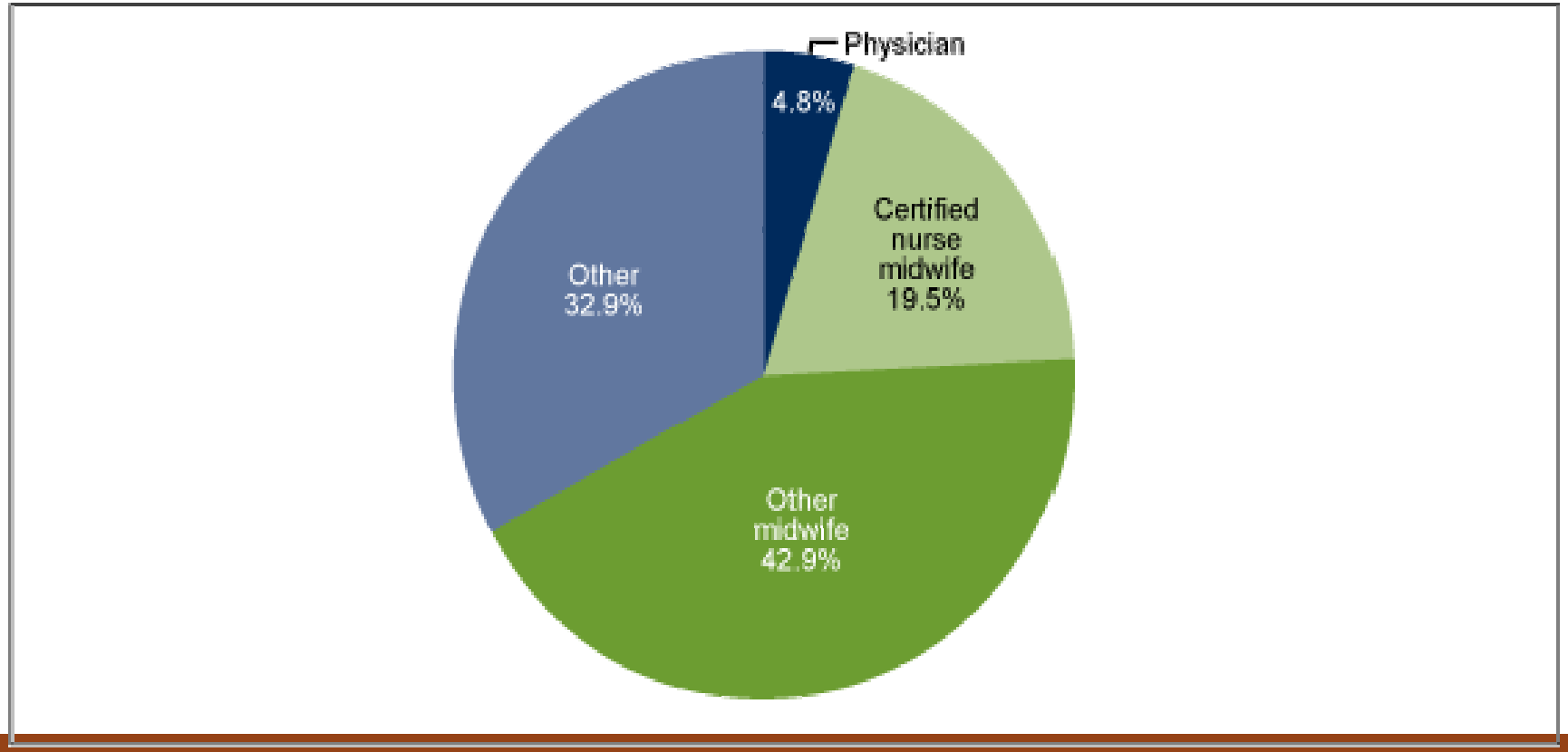
- *For non-Hispanic white women,* ***home births increased by 36%****, from 2004-2009, and 29% overall.*
- *About* ***1 in every 90 births*** *for non-Hispanic white women is* ***now a home birth****.*
- *In 2009, there were* ***29,650*** *home births in the United States*

MOST HOMEBIRTHS ARE ATTENDED BY MIDWIVES:

-62% of home births were attended by midwives: 19% by CNM and 43% by other midwives.

-33% were reported as delivered by "other" (a family member or emergency medical technician)

Figure 4. Percent distribution of home births, by type of birth attendant: United States, 2009



- *SOURCE: CDC/NCHS, birth certificate data from the National Vital Statistics System.*

Research shows…

Collaborative care throughout the antepartum, intrapartum, and postpartum periods is crucial to safety whenever birth is planned outside the hospital setting.

Physicians & Midwives in North America Report:

- Feelings of discomfort & friction during interprofessional consultations related to planned home birth

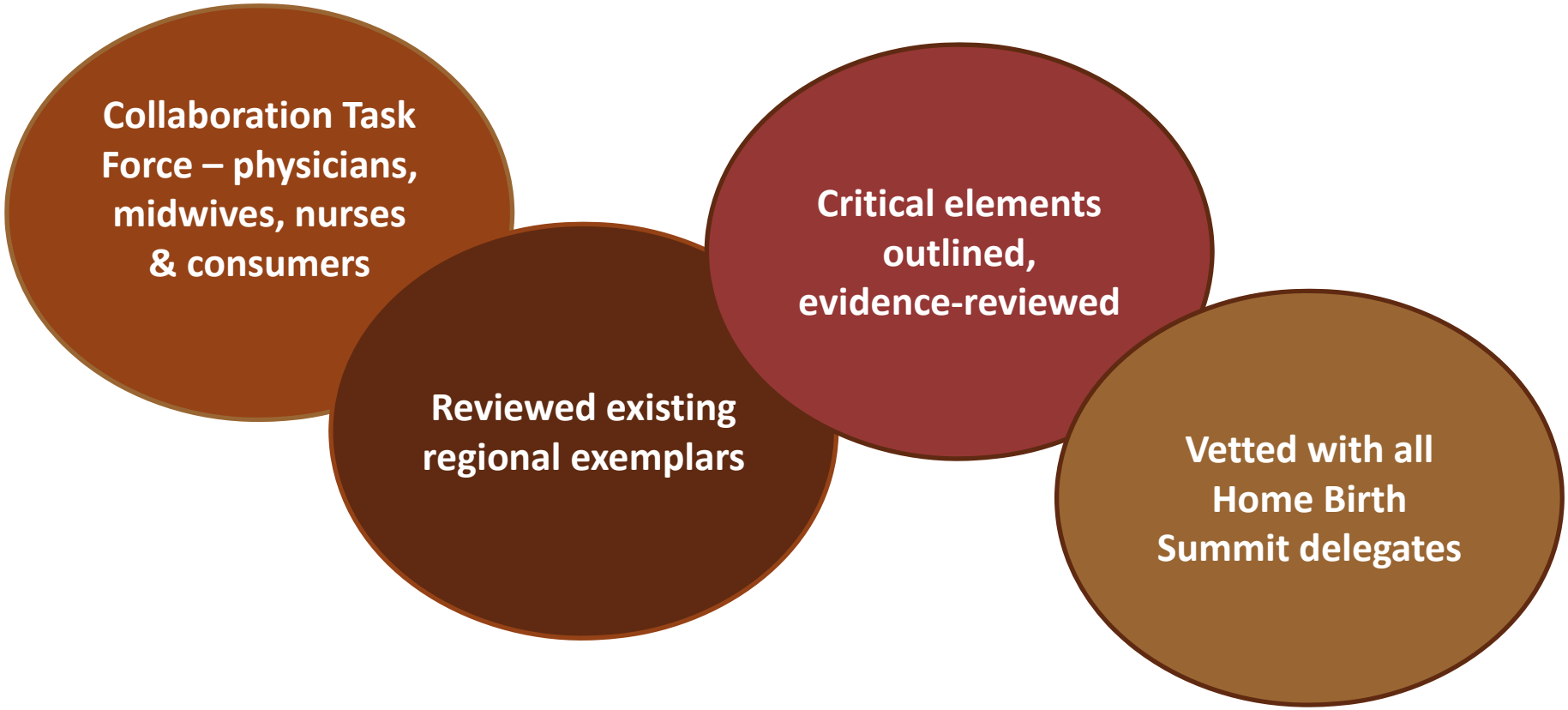
Health Outcomes & Satisfaction Improved by:

- Coordinating care & communication of expectations during transfer of care between birth settings

Sources: Guise J, Segel S. *Teamwork in obstetric critical care*. Best Pract Res Cl Ob (2008); The Joint Commission *Preventing Maternal Death* (2010); Nieuwenhuijze N, Kane Low L. *Facilitating Women's Choice in Maternity Care*. J of Clinical Ethics (2013); Cheyney M, Everson C, Burcher P. *Homebirth transfers in the United States: narratives of risk, fear, and mutual accommodation*. Qual Health Res (2014).

Best Practice Guidelines: Transfer from Planned Home Birth to Hospital

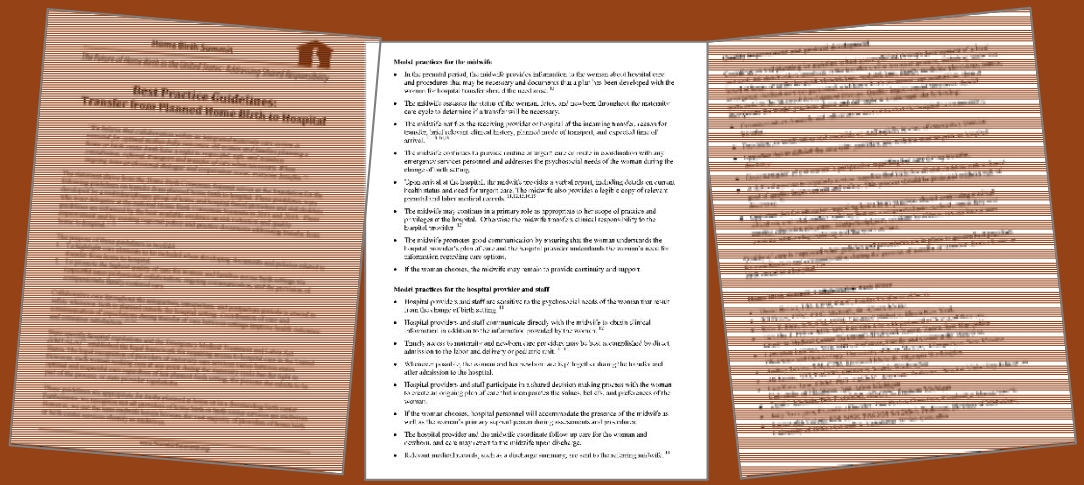
Development Process



The Guidelines

- Appropriate for births planned for home or birth center
- Focus on the consumer
- Provided as open source to encourage widespread adoption

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



Best Practice Guidelines: Transfer from Planned Home Birth to Hospital

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Model practices for the midwife

Model practices for hospital-based care provider and staff

Quality improvement and policy development

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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.

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.

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Timely access to maternity and newborn care providers may be best accomplished by direct admission to the labor and delivery or pediatric unit.

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Quality improvement & policy development

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Policies and quality improvement processes should incorporate the model practices …

Dissemination

Publication

- Journal of Midwifery & Women's Health. *Transfer from Planned Home Birth to Hospital: Improving Interprofessional Collaboration.* Nov. 2014

Poster Presentations

- Lamaze & DONA – September 2014
- AAFP - *Family Centered Maternity Care – July 2014*

Conferences

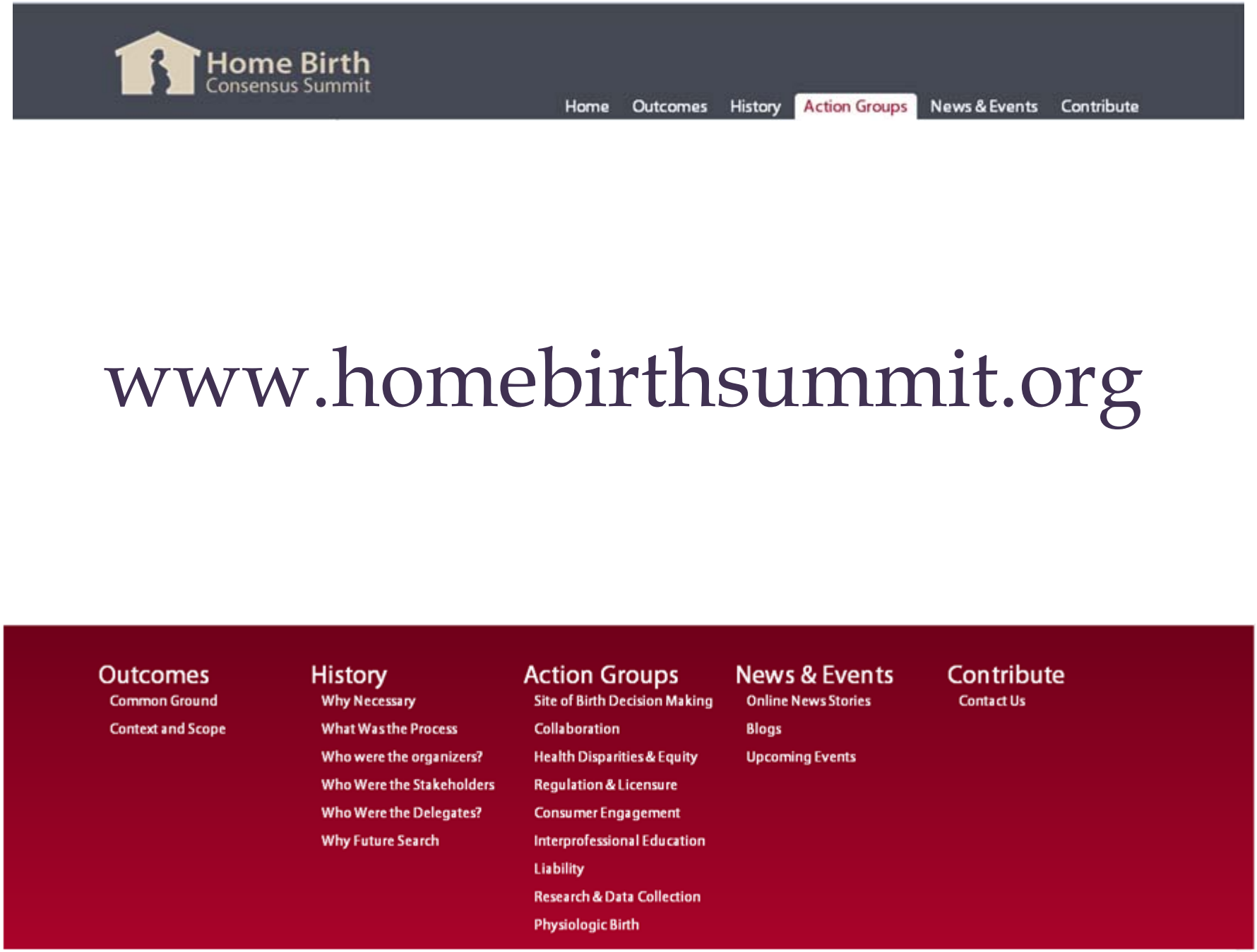
- *MANA – October 2014*
- *ACOOG – Spring 2015*
- *ACNM – June 2015*
- *ACOG – abstract submitted – Annual Meeting 2015*

Webinar

- *NACPM*

Hospital Presentations

- Smooth Transitions – Washington State
- Michigan State



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