Smooth Transitions:
Enhancing the Safety of Hospital Transfers from Planned Community-Based Births

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Disclosures

The speakers have no conflicts of interest to disclose

Learning Objectives

At the conclusion of this presentation, participants will be able to:

- ✓ Describe the national context for this work
- ✓ Understand the benefits of a quality improvement program that addresses transfers from planned community-based births
- ✓ Understand how to develop such a program at their hospital

Why Smooth Transitions?

- Community-based birth is chosen by a small but growing number of families
- Physician and hospital services will be needed for mother or baby in approximately 10 – 20% of planned community-based births
- Lack of systemic supports for smooth transfer of care

2014 WA Births – by Location

Total births	88,428	
Hospitals	82,061	92.8%
Federal Facility	3,283	3.7%
Home	1,777	2.0%
Birth Centers	1,195	1.4%
Born on Arrival	94	0.1%
Other/Unknown	18	0.02%

Source: Center for Health Statistics, Washington State Department of Health, 07/2015.

2014 WA Births – by Attendant

Total Births	88,428	
MD	72,230	81.7%
DO	3,923	4.4%
CNM	8,650	9.8%
LM	2,699	3.1%
Other midwife	265	0.3%
Nurse	442	0.5%
Hospital Administrator	39	0.04%
Father	66	0.07%

Source: Center for Health Statistics, Washington State Department of Health, 07/2015.

Community-Based Births in WA State

- In 2014 3.1% of Washington's births were attended by licensed midwives (N=2,972); up from 1.6% in 2003 (increase of 100%)
- 60% at home
  40% in licensed freestanding birth centers
- Washington's home birth rate is more than twice the national rate; birth center rate is more than triple the national rate
- Majority (94%) of community-based births are attended by Licensed Midwives (LMs)
- There are currently 168 LMs in the state and 17 licensed freestanding birth centers

Intrapartum Hospital Transfers

- Intrapartum transfer rates range from 10.9% – 20% (about 580 transfers/year from community-based births in WA State)
- Intrapartum transfer rate for primips=22.9%; rate for multips=7.5%
- **96.5% are non-urgent**
  - 55.9% of IP transfers for prolonged labor, exhaustion, or maternal request for pain relief; 56.1% receive epidurals; 22% receive oxytocin augmentation
  - 53.2% of those transferred deliver vaginally
- Overall c-section rate for planned home births = 5.2%

Cheyney, M., Bovbjerg, M., Everson, C., Gordon, W., Hannibal, D. & Vedam, S. (2014). Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009. *Journal of Midwifery & Women's Health, 59*, 17–27.

Hutcheson, J., & Benedetti MD, T. (2009). Personal communications. Group Health.

Postpartum and Newborn Hospital Transfers

- 1.5% mothers were transferred immediately postpartum, primarily for hemorrhage and retained placenta
- 0.9% newborns were transferred after birth, primarily for respiratory problems

Cheyney, M., Bovbjerg, M., Everson, C., Gordon, W., Hannibal, D. & Vedam, S. (2014). Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009. *Journal of Midwifery & Women's Health, 59*, 17–27.

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Historically, hospital transfers from community-based births have not always gone well…

Both “sides” have a role in ensuring safe and efficient transfers of care

Obstacles reported by hospital-based providers:

- Belief that home birth is unsafe
- Burden of assuming care of unknown patient with elevated risk
- Working with “difficult” patients or “difficult” midwives

Obstacles reported by midwives:

- Research questioning the safety of home birth
- Co-negotiated assessment of risk is an unfamiliar or uncomfortable concept for physicians
- Feeling judged by the “exception rather than rule”

The National Context

2016 ACOG Statement on Home Birth:

Although the Committee on Obstetric Practice believes that hospitals and accredited birthing centers are the safest setting for birth, it respects the right of a woman to make a medically informed decision about delivery.

Ready access to consultation, and assurance of safe and timely transport to nearby hospitals are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes.

American College of Obstetricians and Gynecologists. (2016). Committee Opinion No. 669: Planned home birth. *Obstet Gynecol, 128*, e26–31.

The National Context

AWHONN Position Statement on Midwifery:

AWHONN supports a woman's right to choose and have access to a full range of providers and settings for pregnancy, birth and women's health care.

Effective communication between all types of health care professionals is essential to provide safe and effective care of women and newborns and is especially critical when the patient's care occurs in more than one care setting.

Association of Women's Health, Obstetric and Neonatal Nurses. (2016). AWHONN Position Statement: Midwifery. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 45*(3), 454-457.

The National Context

ACOG & Society for Maternal-Fetal Medicine Consensus Statement on Levels of Maternal Care 2015

Recognizes freestanding birth centers as appropriate delivery sites for low-risk pregnant women and licensed midwives and certified professional midwives (CPMs) as appropriate providers in these settings

American College of Obstetricians and Gynecologists & Society for Maternal Fetal Medicine. (2015). Obstetric care consensus no. 2: Levels of maternal care. *Obstet Gynecol, 125*, 502-515.

The National Context

Home Birth Consensus Summit, October 2011

Statement on Collaboration:

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.

Home Birth Summit. (2011). Common ground statements. Retrieved from http://www.homebirthsummit.org/summits/vision/statements/

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Home Birth Summit Collaboration Workgroup

Best Practice Guidelines: Transfer from Planned Home Birth to Hospital

May 2014

Model Practices for the Midwife

In the prenatal period, the midwife should provide information to the woman about hospital care and procedures that may be necessary and should document that a plan has been developed with the woman for hospital transfer should the need arise.

Model Practices for the Midwife

The midwife should assess the status of the woman, fetus, and newborn throughout the maternity care cycle to determine if a transfer will be necessary.

Photo credit: www.littlelaphoto.com

Model Practices for the Midwife

The midwife should notify 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.

Model Practices for the Midwife

The midwife should continue to provide routine or urgent care en route in coordination with any emergency services personnel and should address the psychosocial needs of the woman during the change of birth setting.

Model Practices for the Midwife

Upon arrival at the hospital, the midwife should provide a verbal report, including details on current health status and need for urgent care. The midwife should also provide a legible copy of relevant prenatal and labor medical records.

Model Practices for the Midwife

The midwife may continue in a primary role as appropriate to her scope of practice and privileges at the hospital. Otherwise the midwife should transfer clinical responsibility to the hospital provider.

Model Practices for the Midwife

The midwife should promote 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.

Model Practices for the Midwife

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 should be sensitive to the psychosocial needs of the woman that result from the change of birth setting.

Photo credit: www.vivienstembridge.com

Model Practices for the Hospital Provider and Staff

Hospital providers and staff should communicate directly with the midwife to obtain clinical information in addition to the information provided by the woman.

Model Practices for the Hospital Provider and Staff

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

Model Practices for the Hospital Provider and Staff

Whenever possible, the woman and her newborn should be kept together during the transfer and after admission to the hospital.

Model Practices for the Hospital Provider and Staff

Hospital providers and staff should 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.

Model Practices for the Hospital Provider and Staff

If the woman chooses, hospital personnel should accommodate the presence of the midwife as well as the woman's primary support person during assessments and procedures.

Model Practices for the Hospital Provider and Staff

The hospital provider and the midwife should coordinate follow up care for the woman and newborn, and care may revert to the midwife upon discharge.

Model Practices for the Hospital Provider and Staff

Relevant medical records, such as a discharge summary, should be sent to the referring midwife.

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Evolution of Smooth Transitions

- RCW 18.50 and WAC 246-834
- The Midwives Association of Washington State (MAWS)
- DOH - Perinatal Advisory Committee (PAC)
- MD/LM Workgroup – First convened in September 2005 as a subcommittee of the PAC
  - Charge: *To study and improve the process of transferring women and their babies from a planned home or birth center location to an acute-care hospital when a higher level of care becomes necessary*
  - Smooth Transitions - 2009

Smooth Transitions

A Quality Improvement Initiative of the WA State Perinatal Collaborative

www.waperinatal.org

Smooth Transitions

A voluntary, free, customizable program to help hospitals:

- ✓ Improve the efficiency of transfers from planned community-based births
- ✓ Enhance patient safety
- ✓ Promote greater satisfaction for all parties involved

Smooth Transitions

Goals:

- ✓ Build greater understanding between community-based midwives and hospital personnel
- ✓ Improve interactions between providers when transfers occur
- ✓ Increase probability of safe and satisfying care for mothers and babies

Getting Started

- Download the materials from the website: www.waperinatal.org
- Hire a Project Coordinator
- Identify an OB and MW champion to collaboratively introduce the program at hospitals throughout the state

Smooth Transitions
Next Steps

- Form a Perinatal Transfer Committee
  - Local Licensed Midwives
  - Obstetricians, Family Physicians, CNMs
  - Emergency Department Physician & Nursing Leadership
  - Obstetrics Nurse Manager
  - Obstetrics Charge Nurses
  - Pediatricians, NICU or Special Care Nursery staff
  - Hospital Administration Representatives (including risk management department)
  - EMS personnel

Smooth Transitions
Next Steps

- Committee develops a transfer protocol - may adapt the template provided in the Smooth Transitions Project Manual
- Committee adopts the Best Practice Guidelines: Transfer of Care from Planned Home Birth to Hospital and recommends that these best practices be implemented in their community
- Committee decides whether to use or adapt transfer forms developed by the Home Birth Summit Collaboration Task Force (available on HBS website: www.homebirthsummit.org)

Smooth Transitions Follow-up

- Perinatal Transfer Committee meets 2 – 3 times/year to review transfers
- Share successes, identify areas that need improvement, and problem-solve together
- Collect data

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Models that work

- OB hospitalist programs
- Midwife-to-midwife transfers of care for non-emergent clinical situations
- Provide ongoing training for both hospital staff and community-based midwives on best practices for transfers of care
- Create opportunities for cross-professional relationship-building—for example, invite community-based midwives to participate in simulation labs and skills training with hospital staff (NRP, emergency skills)

Models that work

- **Legacy Emanuel Hospital – Portland, OR**

In 2006, Dr. Duncan Neilson, Chief of Women's Health Services, began to implement "wholesale structural and cultural changes" designed to make all five hospitals in the Legacy system "more appealing to women who start delivering at home and to the midwives who help them—thus providing a safe and welcoming alternative when problems arise."

- **Providence Regional Medical Center – Everett, WA**

"I want to be clear that I don't support home birth but if women are going to choose it, then my job is to help it be as safe as it can be if they need to come to the hospital."-Frank Andersen, MD

Models that work

- **Yakima Valley Memorial Hospital – Yakima, WA**

"Like many hospitals, we struggled with how best to accommodate our laboring mothers who planned an out-of-hospital birth, but were transferred during labor for various reasons. Providers complained about the lack of advance communication, midwives complained about the negative attitudes encountered, and the end result was an often unpleasant, and occasionally unsafe birthing experience. With the help of Smooth Transitions, we have gotten our providers, nurses, and administrators together with most of the midwives in central Washington and have significantly changed the attitudes and the experience of home birth transfers."-Roger Rowles, MD

Smooth Transitions

THANK YOU!

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