Planned Home/Birth Center Birth to M Health Transfer of Care Guidelines
Midwife to Midwife Labor & Birth, Family Medicine Baby Care

Goal: Consistent with the 2013 *Best Practice Guidelines: Transfer from Planned Home Birth to Hospital* from the Home Birth Summit, the goal is to promote the highest quality of care for women and families across birth settings via respectful interprofessional collaboration, ongoing communication, and the provision of compassionate family-centered care.

Some facts:

- According to the CDC, home birth and birth center birth have increased by 66.7% from 2007-2015 (still less than 2% of all births; 63.1% home birth, 30.9% freestanding birth center,). This number is expected to rise (Martin et al., 2017; MacDorman et al., 2014).
- After the onset of labor, about 1 in 10 women planning a home birth will transfer to a hospital, the majority for **non-urgent** reasons such as failure to progress (most are nulliparous women).
- When seamless coordination of care occurs, research suggests that fewer neonatal and maternal deaths occur during critical obstetric events (Vedam et al., 2014).

For safe facilitation of planned home/birth center birth to hospital transfer, the non-M Health provider (may be CNM or CPM) must identify emergent or non-emergent conditions (see below) and do the following:

1. Provide information to the woman prenatally and prior to labor about hospital care and procedures that may be necessary and documents a plan has been developed with the woman for hospital transfer should need arise (consistent with Minnesota Statute 147D).

2. Notify the receiving on-call M Health CNM or M Health OB/GYN MD of the incoming transfer, reason for transfer, brief relevant clinical history, planned mode of transport, and expected time of arrival at University of Minnesota Medical Center **West Bank** campus.

3. Labor and delivery unit (UMMC Birthplace) is on the 4th Floor of the East Building. 2450 Riverside Ave. Minneapolis, MN 55454.

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

5. Provide a verbal report, including details on current status and need for urgent care. The non-M Health provider shall also provide a copy of the prenatal record, labor record, and the documents that they are required to maintain under Minnesota Statute 147D (i.e. the written

plan, informed consent, and medical consultation plan). **Report to include plans for newborn care and timely screening after discharge.**

6. If the woman chooses, the non-M Health provider may continue to provide supportive physical and psychosocial care. The non-M Health provider can provide no medical or obstetrical care of any kind other than labor support and emotional support as may be provided under traditional doula services and only with the consent of the patient and in keeping with hospital HIPAA regulations.

7. The non-M Health provider promotes optimal communication by ensuring that the woman understands the M Health CNM or MD plan of care and the hospital provider understands the woman's need for information regarding care options.

8. The non-M Health provider's name and telephone number will be placed in the patient's problem list in order to facilitate communication and discharge follow-up planning for both mom and baby.

Clinical responsibility is transferred to the M Health CNM or M Health OB/GYN MD as deemed appropriate by CNM and MD consultation

The M Health Provider will:

1. Communicate directly with the non-M Health provider to obtain clinical information in addition to information provided by the woman.

2. If the woman chooses, the M Health provider will accommodate the presence of the non-M Health provider as well as the woman's support person(s) during assessments and procedures.

3. The M Health CNM will consult with M Health OB/GYN MD as clinically indicated.

4. The M Health provider will coordinate with non-M Health provider to arrange follow up care for the woman and newborn, and care may revert to the non-M Health provider upon discharge (per the patient's wishes). M Health CNM will contact non-M Health provider to give discharge report.

5. Relevant medical records, such as the discharge summary, are sent to the referring non-M Health provider for discharge coordination with the appropriate patient authorization (Authorization for Release of Protected Health Information - form 155306).

Non-Emergent Conditions (M Health CNM will assume care and consult as clinically indicated):

- Breech presentation in latent labor with reassuring fetal status
- Failure to progress in 1st stage with reassuring fetal status
- Failure to progress in 2nd stage with reassuring fetal status
- Maternal request for pain relief with reassuring fetal status
- Maternal Exhaustion with reassuring fetal status
- Meconium-stained amniotic fluid with reassuring fetal status
- Prolonged or premature ROM with reassuring fetal status
- Malpresentation in *latent* labor (For example, compound presentation, brow, face or other non-specified abnormal lie) with reassuring fetal status
- Pre-eclampsia w/o severe features or Gestational HTN with reassuring fetal status
- Third or Fourth degree laceration requiring repair
- Client's desire for transfer
- Other – to be determined on admission following consultation with M Health OB/GYN MD, and with collaboration between M Health CNM and OB/GYN MD

Emergent conditions (M Health OB/GYN MD will be consulted or assume care immediately):

- Breech presentation in active labor
- Maternal Fever (temp >38.0 C/ >100.4 F)
- Non-reassuring fetal status (Category 2 or 3 fetal heart rate)
- Prolapsed cord or cord presentation
- Hemorrhage (Estimated Blood Loss greater than 500 ml or hemodynamic instability with HR>110 or BP <80/50)
- Malpresentation in *active* labor (For example, compound presentation, brow, face or other non-specified abnormal lie)
- Obstetric shock (Blood pressure <80/50, extremely low urine output, Fever > 38.0 or >100.4 with elevated heart rate >110 or low blood pressure <80/50)
- Suspected placental abruption, placenta previa or other abnormal intrapartum bleeding
- Suspected uterine rupture
- Retained placenta (>2 hours or active bleeding and manual removal unsuccessful)
- Uterine inversion
- Maternal seizure
- Pre-eclampsia with severe features
- Other – to be determined on admission following consultation with M Health OB/GYN MD, and with collaboration between M Health CNM and OB/GYN MD

<u>Best Practice/Quality Improvement</u>

1. Both the non-M Health provider and the M Health providers will debrief case with providers and with the woman prior to discharge.

2. Review transfers with providers involved and hospital leadership (Medical and Midwifery Directors, Nurse Managers, Clinical Nurse Leaders) with shared goal of quality improvement and safety as needed and at least every six months.

Discharge Plan for Women:

Recommended discharge when key milestones are met and deemed safe for discharge:

- Clinical criteria for discharge met
- Vaccinations offered and completed
- Postpartum teaching completed
- Birth certificate and parentage paperwork completed
- Offer and attend discharge class
- Discharge medications available or prescriptions sent
- Follow-up care plan in place (homecare and office visit)

Recommendations for Newborn Care

The M Health Provider (Smiley's Family Medicine) will:

1. Assume care for the newborn after delivery and perform a complete H&P within 24 hrs of delivery (team rounding generally occurs between 7AM and 1PM daily).
2. Communicate with the mother's M Health provider, the non-M Health provider and/or alternate outpatient pediatric provider in order to determine the best discharge plan and follow-up for the newborn.
    a. While our standard process has been well-established to prepare for discharge of healthy babies at 24 hrs after delivery (after routine newborn screening has been completed), we are open to earlier discharge when there is a clear plan for who will assume responsibility for ensuring these recommended tests are completed (see below).

Clinical Conditions that would necessitate **48 hr observation** of the newborn after delivery

1. Untreated or inadequate treatment during labor for GBS-positive mothers
2. Intra-amniotic infection during labor (infant requiring antibiotics)
3. Excessive weight loss (>10%)
4. Jaundice within the first 24 hrs
5. Signs/symptoms of neonatal abstinence syndrome or concerning maternal history or exam warranting further evaluation and monitoring
6. Any condition that warranted even initial admission to the NICU for stabilization and/or treatment

UMMCH Routine Discharge Criteria for Newborns

1. Feeding well
    a. Latch score greater than 7, if breastfeeding
    b. Feeding 8-12 times per day
    c. Stable weight loss or supplementation plan, if needed
2. Afebrile, normal vital signs
3. Voiding and stooling

4. Meets GBS criteria for discharge
5. Screening tests completed
    a. Newborn metabolic blood spot screen drawn
    b. Passed pulse-oximetry screening for congenital cardiac heart disease (CCHD)
    c. Passed hearing screen or had 2 hearing attempts prior to discharge
    d. Bilirubin is either low intermediate or lower or if high intermediate or higher, needs to have 2nd completed (6-12 hours) in the hospital prior to discharge
6. If desired, vaccinations completed
7. Follow-up care plan in place (Home Care and office visits)
8. Car Seat trial, if indicated (infant weight <2500g; preterm)

Early Discharge (<24 hrs) Planning

If an early discharge (<24 hrs) is desired, and infant is medically stable, a clear plan for outpatient follow-up and testing should be co-determined by the M Health Provider and non-M Health Provider and documented in the newborn Discharge Summary. This is to include:

1. Minnesota Department of Health (MDH) guidance for early discharge
    a. Metabolic (blood spot) screen (ideal timing 24-48 hrs)
        i. Draw blood prior to discharge regardless of age
        ii. Arrange to collect a subsequent blood spot screen during the optimal time (24-48 hours of life)
    b. Hearing screen
        i. Hearing screen is valid at any age; arrange for outpatient follow-up if needed
    c. Pulse oximetry screening for CCHD (ideal timing 24-48 hrs)
        i. Screening should be performed prior to discharge regardless of age
        ii. Recommend that oxygen saturation levels be assessed at the first well-child check (early screening may not be accurate)
    d. If families decline any newborn screening, MDH requires parents to sign the MDH refusal form
2. Scheduled outpatient provider visit within 24 hours of discharge
    a. Weight check
    b. Evaluate breastfeeding
    c. Evaluate for jaundice and perform bilirubin testing (if indicated)

References

American Academy of Pediatrics Committee on Fetus and Newborn. Policy Statement - Planned Home Birth. *Pediatrics* 2013;131:1016–1020

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. *Journal of Midwifery & Women's Health, 59*(1),17-27.

Home Birth Consensus Summit. (2013). Best transfer guidelines: Transfer from planned home birth to hospital. Retrieved from: http://www.homebirthsummit.org/best-practice-transfer-guidelines/

MacDorman, M. F., Mathews, T. J., & Declercq, E. (2014). Trends in out-of-hospital births in the United States, 1990–2012. NCHS data brief, no 144. Hyattsville, MD: National Center for Health Statistics.

Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2015. National vital statistics report; vol 66, no 1. Hyattsville, MD: National Center for Health Statistics. 2017.

Minnesota Department of Health. Newborn Screening Program. Accessed online: http://www.health.state.mn.us/divs/phl/newborn/index.html

Vedam, S., Leeman, L., Cheyney, M., Fisher, T. J., Myers, S., Low, L. K. and Ruhl, C. (2014), Transfer from planned home birth to hospital: Improving interprofessional collaboration. *Journal of Midwifery & Women's Health, 59*, 624–634. doi: 10.1111/jmwh.12251