Collaboration Across the Continuum:

Safe and Collegial Transfer of Women from Home to Hospital

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Collaboration Across the Continuum

1. Background: Homebirth Summit and Midwife Bridge Club in Minnesota
2. The experience of the Out-of-Hospital Midwife
3. The North Memorial Experience
Background:
Homebirth Summit
and
Midwife Bridge Club in Minnesota

Amanda (Mandy) Huber, APRN, CNM, IBCLC
Disclosure

I have no actual or potential conflict of interest in relation to this program / presentation
Personal Disclosure

However... I do believe that the personal informs the professional (and vice versa).

The outstanding care I received by my CPM team for both my pregnancies & births at home reinforced my belief in the importance for support for safe birth in all locations of the mother/family’s choice.
Home Birth Summit

• 2009 “Vision Team”: representatives from a variety of diverse North American maternity care organizations
• Goal to improve birth options / decrease barriers
• Home birth was identified as a key area: improve interprofessional conflict, safety, and access
• Delegates to the 3 summits from vast breadth of stakeholders
9 Key Stakeholders

- **Home Birth Consumers** (parents and potential parents considering this option)
- **Consumer Representatives** (including doulas, childbirth educators, childbirth and women’s health care reform and information agencies)
- **Home Birth Midwives** (CPM, CNM, LM, CM, traditional, etc.)
- **Maternal-Child Health Collaborating Providers** (including pediatrics, labor and delivery nurses, neonatal care providers, CNMs who facilitate access for hospital admission or consultation)
- **Obstetricians and OB Family Practice Physicians**
- Leaders with expertise in **Health Care Models, Systems, and Hospital Administration**
- **Insurance** (liability and payors)
- **Health Policy, Legislators, Regulators, and Ethicists**
- **Public Health, Research, and Education**

*The Home Birth Summit, 2016*
All delegates agreed that families choosing birth at home should have access to “an organized system that provides transfer to hospital-based services when needed”.

The Home Birth Summit, 2016
Common Ground Principles, Statements, and Task Forces

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

*The Home Birth Summit, 2016*
Home Birth Summit

• Three Summits thus far: 2011, 2013, 2014
• Tasks forces to continue the work of each guiding principle
• Focus on equity, ethics, & evidence
• Outcomes of the Summits
  • Best Practice Guidelines
  • Model Transfer Forms
  • Consumer engagement
  • Increase in interprofessional collaboration and education
Home Birth Summit: Guidelines

• Best Practice Guidelines: Transfer from Planned Home Birth to Hospital
• Written by the Collaboration Task Force
• Endorsed by many organizations and individuals (too many to list)
  • Midwives Alliance of North America (MANA)
  • American College of Nurse Midwives (ACNM)
  • National Association of Certified Professional Midwives (NACPM)
  • North American Registry of Midwives (NARM)
  • Lamaze International
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.”

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
Three model transfer forms were created to help homebirth providers plan and provide a transfer of care to a hospital setting, and for the receiving hospital provider to receive the transfer:

- Maternal Transfer Form
- Newborn Transfer Form
- Nurse Triage Transfer Form (SBAR form for receiving a triage call re: transfer of care)
| Patient’s Full Name: _______________________________ Weeks Gestation: ______ Date/Time: _____ / ____ : ____  |
|-------------------------------------------------|---------------------------------|
| Age: _____ G: ___ P: _____ EDD: _______ Based on: ☐ LMP/Conception ☐ Dating Ultrasound |
| Referring Provider ______________________________ Contact#: (___) ____ _______ |
| Name of person receiving call: ____________________________ Time Called: __________________ |
| Does receiving hospital have medical records: ☐ YES ☐ NO ☐ UNKNOWN |
| Medical Records Included: ☐ # pages ________ |

**SITUATION** and Reason for Transport

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Status at Time of Transport: ☐ Stable ☐ Unstable

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*Home Birth Consensus Summit, 2013*
Background: The MN Birth Story

• In MN Nurse Midwives’ certification is through AMCB. CNMs are licensed as RNs and APRNs by the MN Board of Nurse. APRN Licensure is fairly new (since 2015) and is mandatory for APRNs.

• In MN certification for Certified Professional Midwives is through North American Registry of Midwives (NARM)

• CPMs may elect to be licensed as a Licensed Midwives through the MN Board of Medicine
Background: The MN Birth Story

• 2010: first accredited out of hospital birth center “Health Foundations” (CPM owned and operated)
• 2010: MN Legislation passed licensing birth centers and allowing Medicaid coverage for birth at out of hospital birth centers
• Increase in % of birth at home in MN
  • 2004  0.5%
  • 2009  0.72%
  • 2014  1.1%

Hamilton, Martin, Osterman, 2015
MacDorman, Mathews, Declercq, 2012
Background: MN Midwives

• Minnesota ACNM Affiliate: 262 CNM members
• Minnesota Council of Certified Professional Midwives (MCCPM): 52 members (33 CPMs, 11 CNMs, etc)
• Prior to the “Bridge Club” there was no formal communication or relationship between the groups
• 2014: First meeting of the Bridge Club
• Concept based on the national level Bridge Club between MANA & ACNM
• Initial goal was to create connections and relationships between midwives and promote collegiality
Bridge Club Logistics

• Participants
  • Certified Professional Midwives
  • Certified Nurse Midwives (in hospital and out of hospital)
  • Midwife students and apprentices (SNMs and CPM students/apprentices)
• Site: “neutral” locations incl. birth centers (both CNM and CPM owned and operated) and childbirth education centers
• Light refreshments: chocolate, water and wine
• Self-introductions at the start of each meeting
• No formal agenda, no committees, no fees, no leadership structure
• Communication: Facebook group, email, word of mouth
Bridge Club Meeting

Next meeting: November 15, 2016 (Location TBA)
Bridge Club: Meeting Content

Meetings initially focused on “getting to know you” between the individual midwives, as well as increasing awareness between the different types of midwives

• Education & training pathways
• Scope of practice
• Guidelines and protocols
• Barriers to providing care
• Legislation
Bridge Club: Home to Hospital Transfers

The main topic of interest by the “Bridge Club” has been facilitating relationships for midwife to midwife transfers from intended home birth to hospital setting.
Outcomes of Bridge Club: Dispel fear

“The oldest and strongest emotion of mankind is fear, and the oldest and strongest kind of fear is fear of the unknown”
— H.P. Lovecraft

Old fears

* CNMs/hospital practice
  * Concern re: reputation among local CNM colleagues & OB collaborators
  * Fear of liability & ramifications from events occurring prior to transferring care
  * Fear of becoming the “go to” site

* CPMs / OOH CNMs
  * Fear of unprofessional behavior to birth provider
    (eg “no prenatal care”, “un-doctored patient”, “midwife abandoned her”, “train wreck”)
  * Concern over disrespectful treatment of laboring woman & her choices
  * No control over what team assumed care of the woman
Outcomes of Bridge Club: Relationships

Formal relationship between ACNM Affiliate and MCCPM

- Representatives from each group attending each other group’s meetings
- Building connections between task forces on similar issues
  eg ACNM Diversity & Inclusion task force and the MCCPM group Anti-Racism and Oppression in Midwifery

Informal relationships amongst local midwives

- Growth of collegial relationships
- Friendships

Building relationships increased trust & confidence
Outcomes of Bridge Club

Bottom line is better care for women and families: improved access, transparency, consistency, collaboration and respect in the transfer process
Collaboration Across the Continuum

The experience of the Out-of-Hospital Midwife

Aly Folin CPM, LM
A Little About Me
Background on CPM/LMs

• Provide comprehensive care through childbearing year – antepartum, intrapartum, postpartum and newborn care including offering all routine antepartum labwork and newborn screenings

• Attend birth at home or birth center setting for low-risk healthy birthing people

• If situation arises where a higher level of care is needed – AP/IP/PP/NB – transfer/transport to an appropriate provider in hospital
Transports of the past

- Patients treated poorly because of choice of birthplace
- Midwife treated poorly even though they were accessing a higher level of care for their patient appropriately
- Gaps in care due to mistrust/uncertainty of how to handle patients transferring in
- Fostered fear among out-of-hospital providers re: complaints, or poor treatment for themselves or their patients – leading to staying home too long in some cases
Transports Now

• In the Metro area, increased familiarity with homebirth as numbers have increased and the advent of birth centers
• Adoption of EMRs for OOH midwives make our records more uniform – easier for hospital providers to interpret information
• Increased numbers and types of openly friendly providers
• Midwife to midwife transfers have only improved our and our patients’ experiences of transport
• Still experience less than optimal transports outstate and in outer ring suburbs
Most Common Reasons for Midwife to Midwife Transfer/Transport

• Antepartum
  • Gestational HTN or Mild Pre-Eclampsia
  • Post dates (fetal surveillance or induction)

• Intrapartum
  • Failure to progress in 1\textsuperscript{st} or 2\textsuperscript{nd} Stage
  • Prolonged ROM
  • Maternal request for pain relief

• Postpartum
  • 3\textsuperscript{rd} degree laceration repair
Inception and Evolution of the project

• Started by Mandy Huber and North Memorial Midwives and expanded by MCCPM
  • Mandy approached our practice and one or two others to start a conversation around home/birth center to CNM care in the hospital at HCMC
  • In MCCPM we agreed to start proactively starting to build these relationships in January of 2014
  • Committee who would reach out and set up meetings with different CNM practices in the state – mostly in the metro area and a few midwives would meet with the CNMs and talk over the various issues
  • Out of these conversations MCCPM and the MN chapter of ACNM have jointly endorsed the Homebirth Consensus Summit: Best Transfer Guidelines.
Midwife to Midwife relationships

• North Memorial
• M health
• Park Nicollet Midwives in Shakopee
• Hudson
• Abbott
• Outstate: Long Prairie, Staples, Alexandria, Glenwood
• Consult/Procedures available at MBC and Willow
“Beautiful Birth can happen anywhere!”

--Rebecca Polston
How does it work?

• Each practice comes up with a policy/guideline for midwives if they want to be able to transfer there
  • For example, some practices are not comfortable if a patient declines Gestational Diabetes Testing, or GBS screening. Or the practice would like the client to have at least one visit on file if they might want to transfer so that a chart is established.

• How to contact them

• OOH midwife makes the determination and calls the on-call midwife and explains situation and the receiving midwife decides if they can/will accept the transfer

• Midwife and client arrive and midwife provides Report and records for care so far – either faxed in ahead of time or printed/copied upon arrival
Why are these policies and relationships important?

• Interprofessional Communication/Trust
• Seamless Transfers
• Patient Education and Informed Choice
• Opportunities for quality improvement for both hospital and out-of-hospital practices
• Decreases anxiety among out-of-hospital providers regarding transports to hospital which leads to transferring sooner
• Decreases anxiety among hospital providers re: unknowns of caring for families choosing out-of-hospital birth
• Increases number of places where seamless transports are possible which decreases pressure on any one location
Out-of-hospital midwife experiences of Midwife to Midwife Transfers

• Most experiences have been positive
• Transferring midwife feels well-respected and treated as a colleague rather than adversary
• Even when transition to OB care was necessary, midwives feel like a member of the care team
• Care has been outstanding
Patient Experiences of Midwife to Midwife Transfers

• Patients feel well-supported when their planned location of birth has to change

• Treated respectfully, not punished for planning a home or birth center birth

• Feel they have been given every option even when transition to OB care needs to happen
How can we improve?

• Biggest problem identified is trouble getting appointments – getting past administrative hurdles
• Communication between midwives is generally good – do we need more formalized case review with broader hospital staff?
Next Steps

• Every hospital/practice should have a home to hospital transfer protocol/guideline for both emergent and non-emergent transfers

• Communication between providers after each birth to ensure ongoing quality improvement and smooth relationships for all parties
Thank you to all the midwives who have made this happen!
Collaboration Across The Continuum: The North Memorial Experience

Safe and collegial transfer of women from home to hospital

Teresa Jarvis, APRN, CNM
North Memorial Women’s Specialty Services

Jennifer Tessmer-Tuck, MD
North Memorial Laborist Associates

North Memorial Medical Center
Robbinsdale, Minnesota
Objectives

• Describe North Memorial Medical Center’s policy for transfer of care from an intended out-of-hospital birth environment to the hospital

• Explain how North Memorial Medical Center utilizes a team of Certified Nurse Midwives and OB/GYN Hospitalists to welcome women and their providers from an intended out-of-hospital birth environment to the hospital when needed
Objectives (cont.)

• Define North Memorial Medical Center’s criteria for risk stratification of women, which allows many women to continue hospital care with a Certified Nurse Midwife

• Provide attendees the necessary information to implement a similar policy on their hospital units, with the goal of optimizing the quality and safety of care for all women and fetuses
“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 the 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.”
• 518 beds
• Healthgrades
  – Consistently recognized as a TOP 50 hospital
• Level 1 Trauma Center
  – Blood bank on site
• Level IIIC NICU
  – Accept/Admit as early as 23 0/7 weeks
  – Transfer out only for newborn surgery
  – 24/7 on-site Neonatal Nurse Practitioner, MD within 30 min.
• Highest level maternity care
  – OB/GYN hospitalist 24/7
  – U of MN Maternal Fetal Medicine physicians on site 2 days per week and 24/7 for phone consultation
About our practice

- 4 Certified Nurse Midwives
  - See patients at 2 clinics –
    - Robbinsdale (hospital campus) and Brooklyn Park
  - Attend all births for midwife practice patients
  - Offer water birth
  - Offer nitrous oxide
  - Offer Vaginal Birth after Cesarean (VBAC) with one or two previous cesarean deliveries
- Two OB/GYN physicians in the clinic to support high-risk patients as needed
About our practice (cont.)

• 5 OB/GYN Hospitalist physicians
  – No office practice
  – Work 24-hour shifts in the hospital
  – Dedicated to Labor and Delivery
  – Collaborative practice with Certified Nurse Midwife team
• OB/GYN Hospitalists associated with:
  – Lower cesarean section rate
  – Higher rates of trials of labor after cesarean (TOLAC)
  – Higher rates of VBAC success
• Allows broader definition of midwife scope of practice
  – We co-manage many patients when other OB/GYN physicians require transfer of care
North Memorial Medical Center - C-section rates

Overall C-section Rate 2013-2015

NTSV C-section Rate 2013-2015
Purpose For Developing an OOH Transfer Policy

• Mutual interest in the health and safety of mothers and fetuses
• Tell our story....
  – Provider to provider transfer (not provider to nurse)
  – Relationship focused
  – Transfer care to a provider with similar care philosophy (midwife to midwife vs. midwife to physician)
  – Get message out to our community that we are a safe place to come when you need a higher level of care
  – Try to be non-biased and non-judgmental in the interest of maternal and fetal safety
Communication and Expectations

- Telephone call from the OOH-midwife to the on call NM-CNM
- Seamless transfer after that phone call
  - Your responsibility is to get woman safely to hospital
  - Our team handles the rest
- NM-CNM communicates to the Labor and Delivery Charge nurse and the OB/GYN hospitalist
- NM-CNM meets woman and OOH-midwife at the hospital
- NM-CNM and OB/GYN hospitalist assess woman together on admission
- NM-CNM and OB/GYN hospitalist determine collaboratively if woman is appropriate for ongoing CNM care or requires physician care (see guidelines)
- OOH-Midwife expected to bring prenatal records to the hospital
- OOH-Midwife expected to accompany woman to the hospital
How NMMC Utilizes The Team

• Expectation of clear and respectful verbal communication between the OOH-midwife, receiving NM-CNM, OB/GYN hospitalist physician, hospital personnel and the patient

• Risk stratification of women and their conditions:
  – Emergent
  – Urgent
  – Non-urgent

• The NM-CNM may assume care of non-urgent patients

• Many times, patients change status from non-urgent to urgent or vice versa
  – Our collaborative process allows patients to easily change their managing provider from CNM to MD or back again
Emergent conditions (threaten life of woman or fetus)

- Require **ambulance** transfer

- Bypass this transfer process we are discussing today—PLEASE DO NOT CALL NM-CNM

- Call 911
Emergent conditions – call 911

- Prolapsed cord or cord presentation
- Active hemorrhage (Estimated Blood Loss greater than 1000 ml or hemodynamic instability with HR > 110 or BP < 80/50)
- Obstetric Shock
  - Blood pressure < 80/50, and/or
  - Extremely low urine output, and/or
  - Fever > 38.0 or > 100.4 with elevated heart rate > 110 or low blood pressure < 80/50
- Suspected uterine rupture
- Uterine inversion
- Maternal seizure
Non-Urgent Conditions (can be managed by CNM)

• Breech/malpresentation in *latent labor* with reassuring fetal status
• Failure to progress in 1\textsuperscript{st} stage with reassuring fetal status
• Failure to progress in 2\textsuperscript{nd} stage with reassuring fetal status
• Maternal request for pain relief with reassuring fetal status
• Maternal Fever (temp >38.0 C/>100.4 F) or chorioamnionitis
• Maternal exhaustion with reassuring fetal status
• Meconium stained amniotic fluid with reassuring fetal status
• Prolonged or premature ROM with reassuring fetal status
• Mild pre-eclampsia or Gestational HTN with reassuring fetal status
• Third or Fourth degree laceration requiring repair
• Other- to be determined on admission following consultation with NMMC OBGYN hospitalist physician
Urgent Conditions (to be managed by physician)

- Breech/Malpresentation in *active labor*
- *Non-reassuring fetal status (Category 2 or 3 fetal heart rate)*
  - Really depends on the situation, collaboration very important here
- Suspected placental abruption, placenta previa or other abnormal intrapartum bleeding
- Severe pre-eclampsia
- Other- to be determined on admission following consultation with NM OBGYN hospitalist
Data

• REALLY limited data on out-of-hospital-to-hospital transfer in the U.S.

• Systematic review of home to hospital transfers in developed countries (Blix, et al. *BMC Pregnancy and Childbirth*, 2014)
  – 10-32% of women transferred from home to hospital

  – All Oregon births 1/1/12 – 12/31/13 (2 years)
  – Oregon home birth rate 2.4% (highest in U.S.)
  – 16.5% of women transferred from home to hospital

• Really NO data on outcomes
  – C-section rates?
  – NICU admission rates?
Reasons for transfer to NMMC (through August 2016)

- G4P1 - pre-eclampsia at 37 2/7 weeks – vaginal
- G1P0 - pain relief – vacuum assisted vaginal
- G5P2 – TOLAC PROM for 25 hours – VBAC
- G1P0 - PROM 24 hours – vaginal
- G1P0 - prolonged 2\(^{nd}\) stage – vaginal
- G1P0 - gestational HTN & IOL – vaginal
- G1P0 - severe anemia – vaginal
- G1P0 - HTN and oligohydramnios – vaginal
- G1P0 - HTN & IOL – vaginal

- G1P0 - PROM – cesarean for 1\(^{st}\) stage arrest
- G3P1 - TOLAC – cesarean for prolonged 2\(^{nd}\) stage, malpresentation
- G2P0 - maternal exhaustion – cesarean for labor arrest
- G1P0 - pre-eclampsia & IOL – cesarean for non-reassuring fetal status
Sources of transfers (through August 2016)

- Roots Community Birth Center
- River Valley Birth Center
- Heritage Midwifery (Maureen Dahl)
- Helping Hands Birth Services (Nickie Kerri-
  
- Aszani Stoddard
- Peacefully Born (Jeanne Bazille)
Route of Delivery for all transferred women (through August 2016)

30% cesarean rate
n = 13 (9/4)
- 1 failed TOLAC
- 25% primary cesarean rate
Route of Delivery for **NULLIPAROUS** transferred women (through August 2016)

- **Cesarean**: 30% cesarean rate
  - **n = 10 (7/3)**
  - 1 for non-reassuring fetal status
NICU admissions transferred women (through August 2016)

23% NICU rate
n = 13 (10/3)
- One 37 2/7 weeks
Dear Teresa,

I want to thank North Memorial Midwives for reaching out to the midwives who practice in the-out-of-hospital setting. You are a ready resource for consultation and a trusted location for transfer of care. You took a leading role in helping develop a transfer-of-care guideline that has helped define excellent midwifery practice both in all practice settings.

Whether I have referred my patients for prenatal evaluation of threatened pre-eclampsia, or have completely transferred care for severe anemia, PIH or late preterm labor, my patients have reported feeling respected and their concerns and fears heard by your CNMs, nurses and hospitalists.

You have demonstrated your commitment to the Midwives Model of Care that is earning you a reputation in the community as one of the leading hospital-based nurse midwifery practices in the Metropolitan area.

I can say for myself and my colleagues, we greatly appreciate your partnership in our shared goal of safe, respectful, women-centered care.

Thank you so very much.

Maureen Dahl CPM, LM
We have had the wonderful opportunity to transport from out-of-hospital midwifery care into hospital midwifery care and cannot stress what a positive experience this has been. Our midwife-to-midwife transports have for non-urgent reasons, but for things that we do not offer outside of the hospital such as pitocin inductions or augmentations. Our clients felt well informed, were made to feel comfortable in a new setting, and they were provided with amazing care. Each time we have transported into the care of CNMs in the hospital, the clients have walked away with nothing but positive things to say about their birth experience and experience of transport. This is amazing since often, in my experience, women transporting to the hospital is often accompanied by feelings of grief. We have not seen that when we have transported into CNM care. The other big thing we have noticed is that when transporting into CNM care in the hospital is that our clients are more willing to engage in discussion about treatment plans and open to options than when we have transferred into more hostile practices. If we go someplace hostile, the client recognizes this immediately and is suddenly afraid to comply with any requests because they don't trust a hostile team. When the transport is smooth and friendly, clients are more open to suggestions and interventions because they can feel that everyone is working for their best interests.

Erika Urban, CPM, LM
River Valley Birth Center
References


References Continued


