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# *Smooth Transitions:*

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## *Enhancing the Safety of Planned Out-of-Hospital Birth Transports*

*A Quality Improvement Initiative of the  
Washington State Perinatal Collaborative*

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*Project Manual*

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*This manual was developed by the LM/MD Workgroup,  
a subcommittee of the Washington State Perinatal  
Advisory Committee*

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LM/MD workgroup Members

Robert Palmer, MD, Workgroup Co-Chair, Washington State ACOG

Audrey Levine, LM, Workgroup Co-Chair, Midwives' Association of WA State

Dale P. Reisner, MD, Washington State Obstetrical Association and Swedish Medical Center

Jane Dimer, MD, Group Health Cooperative and Washington State ACOG

Jo Anne Myers-Ciecko, MPH, Executive Director, Midwifery Education Accreditation Council

Suzy Myers, LM, MPH, Chair of the Department of Midwifery, Bastyr University

Catrina Munro, LM, Owner of the Bellingham Birth Center

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# *Planned Out-of-Hospital Birth Transfer Quality Improvement Project Manual*

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# *Planned Out-of-Hospital Birth Transfer Quality Improvement Project*

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## **Introduction**

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Thank you for your interest in the Planned Out-of-Hospital Birth Transfer Quality Improvement Project. We hope that after reading this manual, you will want to become a participant in this important project.

A subcommittee of the Statewide Perinatal Advisory Committee has developed a voluntary quality improvement project to assist hospitals providing obstetrical services in developing their own program to facilitate transfers of pregnant women, postpartum women or newborns who had planned to deliver in an out-of-hospital setting.

The goal of the quality improvement process is to improve the efficiency of transfers, improve communication between providers, decrease liability, and ultimately improve the safety of the birth process in these specific situations.

Washington has licensed midwives since 1980. Licensed midwives deliver about 2100 babies per year in Washington in birthing centers or in a home environment. Approximately 15 percent of the women who plan an out-of-hospital birth develop intrapartum, or postpartum complications or their babies develop conditions that merit transfer to an acute care hospital. The vast majority of these transfers are for non-emergent indications. In some communities, these transfers are smooth and efficient, while in others there seem to be barriers that can lead to delays.

The voluntary quality improvement process would begin with a brief informational meeting with your obstetrical services committee to explain the program. Volunteer obstetrician and licensed midwife representatives from the State Perinatal Advisory Committee LM/MD workgroup will be available to present information about the quality improvement project and to provide consultation for the process. A similar meeting will be held with the licensed midwives that provide services in your area.

For the quality improvement project, a local transfer protocol will be developed, that lists:

- who the licensed midwife should contact when a transfer becomes indicated,
- where in the hospital the mother should be brought,
- what records should be transferred,
- what the role of the licensed midwife should be in the hospital with respect to her relationship with her client and how to contact the licensed midwife to return the mother to her care following hospital discharge, where appropriate

A sample hospital transfer protocol is included in the appendix and can be easily adapted by your institution.

In order to gather information on each transfer, a sample survey tool has been developed. (See appendix). Prior to hospital discharge, the physician team, the nursing team, the patient, and her

midwife are each given a short survey to complete. This can also be done as an interview. The survey reviews what was successful about the transfer process and what could use improvement. The completed surveys would then be reviewed by the local perinatal transfer committee, providing feedback to both the local obstetrical services committee and the local licensed midwives (who could be part of the local perinatal transfer committee). It is expected that after a year or two, the transfer review process should function smoothly, and be incorporated in the local hospital's quality improvement system. The perinatal transfer committee would be disbanded.

Please share this material with your obstetrics leadership team, institutional quality improvement unit and hospital administration for review. If you would like to have a presentation of the Project by a member of the Licensed Midwife/Physician workgroup or have any questions about the project, please contact Project Coordinator, Melissa Hughes, LM at (206) 697-2226; [melissahughesmidwife@gmail.com](mailto:melissahughesmidwife@gmail.com).

## Midwives in Washington State - Background

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Midwives attend more than 10% of all births in Washington State and virtually all of the planned out-of-hospital births. There are three categories of midwives practicing in the state: licensed midwives, certified nurse-midwives and unlicensed or lay midwives. This paper provides a brief overview of each category and more detailed information about licensed midwives, who attend the majority of births taking place at home or in birth centers.

### Licensed Midwives

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Licensed midwives provide care during the normal childbearing cycle. They are licensed to perform all of the procedures that may be necessary during the course of normal pregnancy, birth and the postpartum/newborn period, including the administration of selected medications. They consult with physicians when a case deviates from normal and refer clients if complications arise. In an emergency, a midwife is trained and equipped to carry out life-saving measures. Licensed midwives generally provide care to women planning to give birth at home or in a birth center. Twelve of the thirteen licensed birth centers in Washington State are owned by licensed midwives.

Licensed midwives are regulated by the State of Washington Department of Health, Midwifery Advisory Committee and disciplined by the State of Washington Department of Health, Health Professions Quality Assurance Division. Professional liability insurance is available in Washington State to licensed midwives through the Midwifery and Birthing Center Professional Liability Insurance Joint Underwriting Association. Licensed midwives are reimbursed for their services by most private insurers and the state Medicaid program (Department of Social and Health Services).

To qualify for licensure in Washington State, a midwife must complete a three-year program or the equivalent approved by the state; participate in a minimum of 100 births; provide primary care, under supervision, for a minimum of 50 women in the prenatal, intrapartum and postpartum periods; and successfully pass the national examination administered by the North American Registry of Midwives as well as an additional state-specific test.

Licensed midwives are described as “direct-entry” midwives because their educational requirements do not include prior training in nursing. Nationally, direct-entry midwives are licensed in 24 states and are qualified for national certification by the North American Registry of Midwives as Certified Professional Midwives. The Midwifery Education Accreditation Council is recognized by the U.S. Secretary of Education as the national accrediting agency for direct-entry midwifery education.

The law regulating midwifery practice in Washington State dates to 1917 when professional midwives were first recognized by the state legislature. There were no in-state training programs at that time and most midwives were foreign-trained professionals who immigrated to Washington. The number of midwives in practice declined into the 1940s and only began to grow again after 1978 when the Seattle Midwifery School was founded and began training midwives to contemporary international standards.

The number of midwives and the percentage of midwife-attended births have grown steadily over the years. There are now approximately 110 licensed midwives in Washington State and in 2009 they attended 2,130 births or 2.5% of the total births in the state. Four counties reported 6% or more of all

births were attended by licensed midwives.<sup>1</sup> According to data collected nationally, approximately 12% of women who begin the process of a planned out-of-hospital birth require transport to an acute-care hospital either during labor, or during the postpartum period. Most of these transports are for non-emergent conditions.<sup>2</sup>

Licensed midwives may start intravenous fluids, maintain saline or heparin locks, administer prophylactic ophthalmic medication, postpartum oxytocin, vitamin K, Rh-immune globulin, local anesthesia for repair, magnesium sulfate for prevention of maternal seizures pending transport, epinephrine for use in maternal anaphylaxis pending transport, terbutaline for non-reassuring fetal heart tones and/or cord prolapse pending transport, antibiotics for intrapartum prophylaxis of Group B streptococcus, anti-hemorrhagic drugs to control postpartum hemorrhage, such as misoprostel per rectum, methylergonovine maleate (oral or intermuscular), prostaglandin 15-methyl F2 alpha (Hemabate), and MMR vaccine to non-immune postpartum and HBIG and HBV for neonates born to hepatitis B-positive mothers. Licensed midwives also carry oxygen and resuscitation equipment and are required to renew their neonatal resuscitation certification (NRP) every two years.

Licensed midwives are required by law to consult with a physician whenever there are “significant deviations from normal” in either the mother or the infant. The Midwives Association of Washington State maintains a list of conditions, informed by the latest evidence, that warrant physician consultation and may require referral and/or transfer of care. This document, [“Indications for Consultation in an Out-of-Hospital Midwifery Practice,”](#)<sup>3</sup> is meant to be used in conjunction with clinical judgment and expertise.

Members of the Midwives Association of Washington State must participate in the Quality Management Program,<sup>4</sup> a quality improvement program approved by the State of Washington in 2004. The program includes both peer review and incident review procedures. The peer review process generally occurs at the regional level and provides for both routine retrospective educational review and prospective evaluation. Incident reviews are initiated when a midwife self-reports certain sentinel events or requests a review or when a [complaint](#) is received from another party. The Midwives Association of Washington State Quality Management Program reviews complaints citing professional members only. In the event that a complaint is filed citing an unlicensed or non-member midwife the party filing the complaint will be notified and directed to file the complaint with the Department of Health.

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<sup>1</sup> Washington State Department of Health, Center for Health Statistics. Birth Data Tables: Natality Table C7. Birth Attendant by County of Occurrence, 2008. <http://www.doh.wa.gov/ehsphl/chs/chs-data/birth/download/2008.xls>

<sup>2</sup> Johnson, Kenneth, C. and Daviss, Betty-Anne. Outcomes of planned home births with certified professional midwives: large prospective study in North America. British Medical Journal. 2005; 330:1416.

<sup>3</sup> Midwives Association of Washington State. Indications for Consultation in an Out-of-Hospital Midwifery Practice (revised 2008). <http://www.washingtonmidwives.org/assets/MAWSindications-4.24.08.pdf>

<sup>4</sup> Midwives Association of Washington State. Quality Management Program. <http://www.washingtonmidwives.org/about-maws/quality-mgmt.html>

## Certified Nurse-Midwives

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All certified nurse-midwives in Washington are licensed as Advanced Registered Nurse Practitioners (ARNPs). They may attend deliveries in hospitals, birth centers, and homes, though most are employed by physicians or hospitals. Certified nurse-midwives can provide gynecological, family planning, and primary care. They have full prescribing authority for both legend and controlled drugs (Drug Enforcement Administration Schedules II—V).

Certified nurse-midwives receive training first as registered nurses and then obtain a graduate degree in the field of nurse-midwifery, focusing on women’s health, pregnancy, birth, and postpartum care. In Washington State, certified nurse-midwives are independent health care providers who work in collaborative relationships with obstetricians, should complications arise. Many hospitals, in the course of granting certified nurse-midwives hospital privileges, require some degree of formal physician supervision or back-up.

Certified nurse midwives carry professional liability insurance provided through a number of carriers. They are reimbursed for their services by all major public and private insurance companies. They are licensed by the State of Washington Department of Licensing, and regulated and disciplined by the State of Washington Department of Health, Nursing Care Quality Assurance Commission.

## Unlicensed or Lay Midwives

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There are also individuals who attend births in Washington State, providing assistance with labor and delivery, who are not licensed by the state. The law regulating direct-entry midwifery practice exempts these individuals from the required licensure so long as they do not advertise or accept payment for their services, including cash, trade, or goods-in-kind. The term "lay midwife" is commonly used to designate an uncertified or unlicensed midwife. Other terms sometime used to describe uncertified or unlicensed midwives are traditional midwife, traditional birth attendant, granny midwife and independent midwife. Some lay midwives refer to themselves as Christian Birth Attendants, or “religious practitioners. Generally, state law exempts religious practitioners from governmental oversight or regulation in recognition of the principle of the state not interfering with the practice of religion. Lay midwives, because they are not licensed by the state, are not the regulated by any state agency or committee.

Persons who feel that they have been injured by a lay midwife have few options. If the lay midwife billed for services, had business cards or advertised their services, the injured party might appeal to the local county prosecuting attorney to file criminal charges relating to the unlicensed practice of midwifery.

## Physician-Licensed Midwife Work Group

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In 2004, Roger Rowles, MD, of Yakima, WA, Chair of the State of Washington Department of Health Statewide Perinatal Advisory Committee appointed a task force to study and improve the process of transferring women and their babies from a planned out-of-hospital birthing location to an acute-care hospital when a higher level of care becomes necessary. This task force is a cooperative effort of obstetrician-gynecologist physician leaders and licensed midwifery leaders as well as those with expertise in public health and policy. The licensed midwife members, working with the Midwives’ Association of Washington State, a voluntary education and advocacy group, have developed a document titled “Planned Out-Of-Hospital Birth Transport Guidelines” (*Appendix B*). These Guidelines have been reviewed and approved by members of the Statewide Perinatal Advisory Committee, the Midwives Association of Washington State, and the Physician-Licensed Midwife Work Group.

## Liability Issues

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Hospitals and physicians will want to consult their legal counsel; however, it is our understanding that the professional liability insurance companies who provide obstetricians and gynecologists with professional liability insurance ask that their insureds not form formal, written consultation agreements with licensed midwives, which might be interpreted as the “loaning” of the physician’s liability policy limits to the licensed midwife. It is our further understanding that these companies do cover their insureds when their insureds are assigned to emergency obstetrical call as a condition of hospital privileges, and are then asked to care for any woman brought into the hospital for obstetrical care, including those women being transported who have been under the care of a licensed midwife.

## How to Incorporate the Planned Out-of-Hospital Birth Transfer Quality Improvement Project in Your Hospital

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1. Review the materials you have received with your obstetrical leadership team, quality improvement staff and your hospital administration.
2. Contact Melissa Hughes, Project Coordinator, by email [melissahughesmidwife@gmail.com](mailto:melissahughesmidwife@gmail.com) or phone (206) 697-2226, to request a presentation about the project for your obstetrical leadership team and hospital administration by one of the volunteer team members of the Licensed Midwife-Physician workgroup. This meeting should include obstetricians, family physicians and certified nurse midwives who practice obstetrics, obstetrical nursing leaders, quality improvement staff, hospital administration representatives, and possibly emergency department physician and nursing leadership. We will send one of our physician team members and if desired, one of our licensed midwife team leaders, to make the presentation and answer questions.
3. Decide if your hospital wishes to participate in the project. If you decide to participate, please contact Melissa Hughes.
4. Designate a lead for this group, who will set up and facilitate the meetings. If available, a hospital quality improvement staff member would be an ideal choice for group leader.
5. Develop a Notification Procedure for Planned Out-of-Hospital Birth Transfers. See sample in the Appendix A. *(Word file available for use and customization upon request)*
6. Develop survey tool. See sample in Appendix C. *(Word file available for use and customization upon request)*
7. Identify the licensed midwives who provide out-of-hospital births in your hospital's service area. Schedule a meeting with your obstetrical physician and nursing leadership team, your local licensed midwives, and a representative of the local emergency medical services. The purpose of this meeting is to get to know each other, describe your interest in participating in this project, and review the notification procedure that you would like your staff and the licensed midwives to follow in case of a transfer. Review and finalize the survey tools., Determine where the surveys will be stored, whether they will be written for interview, how they are distributed, and where they should be returned when completed. Determine staff who will disseminate surveys or complete interviews and who will compile the surveys.
8. Form a Planned Out-of-Hospital Birth Perinatal Transfer Committee, to meet several times a year to review the completed surveys, and provide feedback to improve the efficiency and safety of these Perinatal Transfers. This committee should include physician, nursing, quality improvement staff, licensed midwifery leaders, and a representative of local emergency medical services.
9. We ask that once a year, this committee send a brief summary statement to Melissa Hughes, Project Coordinator. The summary statements of participating hospitals will be reviewed by the

Licensed Midwife/Physician Workgroup in order to evaluate and improve the project and then aggregated and presented to the Perinatal Advisory Committee. Once the perinatal transfer system has been integrated into the hospital's Quality Improvement program at the participating hospital, the committee can be discontinued. *(Word file available for use and customization; Example provided Appendix D)*

## Appendix A

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### Notification Procedure for Out-of-Hospital Birth Perinatal Transfers

#### *Sample*

#### **Generic General Hospital**

1. In case of life-threatening emergency, please call 9-1-1 and request an emergency transfer of your patient to the nearest acute-care hospital that provides obstetrical services
2. In non-life-threatening situations, licensed midwives who are attending a planned out-of-hospital birth who need to transfer a laboring woman, a postpartum woman, or a newborn to our hospital are asked to notify the (insert: Obstetrical Charge Nurse or Nursing Supervisor or other designated responsible party at (\*\*\*) \*\*\*-\*\*\*\*) to notify the hospital about a perinatal transfer. This responsible hospital staff member will take the following steps:
  - A. Notify the Nursing Supervisor about the transfer
  - B. Notify the Obstetrical Charge Nurse about the transfer
  - C. Notify the Emergency Department about the transfer
  - D. Notify the Admitting Office about the transfer
  - E. Notify the Obstetrician, Family Physician or Pediatrician on unassigned patient call about the transfer
3. The licensed midwife should give the responsible hospital staff member the patient's name, date of birth, reason for transfer, brief obstetrical history, brief medical and surgical history, medications and allergies, and any additional information that would help the hospital prepare for the transfer. The licensed midwife should describe the method of transfer (ambulance, private vehicle), and the approximate estimated time of arrival. The responsible hospital staff member should advise the licensed midwife where the patient should be brought to the hospital (Emergency Department, Admitting, Labor and Delivery).
4. The licensed midwife should accompany the patient to the hospital, and then transfer all care of her client to the hospital team. The licensed midwife should provide the hospital staff with a complete copy of her client's antepartum, intrapartum, (and postpartum, if applicable) records, including all laboratory and ultrasound reports. If the licensed midwife only has the originals, the hospital will make a copy, and return all of the originals to the licensed midwife. The licensed midwife should also give a verbal report about her client's status to the nursing staff and the physician.
5. Once being admitted to the hospital, the patient's care is transferred entirely to the hospital staff, with the licensed midwife's role changing from that of primary care provider before arrival at the hospital to companion/support person after arrival at the hospital. Respectful recognition of all parties' roles can only facilitate patient safety and satisfaction. To this end, the licensed midwife should take care to facilitate rather than disrupt communication and trust between the

patient and the hospital staff. Additionally, hospital staff should strive to foster and express a collegial attitude towards the licensed midwife. *(Each hospital may insert conflict resolution details, policies or support already in place to mediate complaints or concerns of patients or transferring midwives.)*

6. After delivery, or at time of discharge from the hospital, four surveys will be distributed: one each to the patient, to the licensed midwife, to the nursing staff, and to the physician, seeking feedback about the transfer process and how it could be improved. These surveys will be returned to the Generic General Hospital's Perinatal Transfer Committee for review. The Perinatal Transfer Committee should meet several times a year, review the surveys, and report the cumulated results to the medical and nursing staff, highlighting the successes of the program and what steps should be taken to improve the program. Ideally, this Perinatal Transfer Committee should include obstetrical nursing and physician leaders, hospital administration, and representatives from the local licensed midwifery community.
7. After the patient is discharged from the hospital, where possible, a copy of the dictated admission history and physical examination, operative report and pathology report if appropriate, and the discharge summary should be sent to the licensed midwife, and where appropriate, the woman should be returned to the licensed midwife's care for postpartum follow-up.

## Appendix B

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# PLANNED OUT-OF-HOSPITAL BIRTH TRANSPORT GUIDELINE

Updated February 2011

PREPARED BY THE MAWS TRANSPORT GUIDELINE COMMITTEE WITH THE  
AD HOC PHYSICIAN – LICENSED MIDWIFE WORKGROUP OF THE  
STATE PERINATAL ADVISORY COMMITTEE



Midwives Association of Washington State

PMB 2246

10002 Aurora Ave N #36

Seattle, WA 98133-9348

1-888-422-4784

[www.washingtonmidwives.org](http://www.washingtonmidwives.org)

## 1. **INTRODUCTION**

This document speaks to an underlying and mutual interest in the health and safety of mother and baby in the event of a transfer from an out-of-hospital birth setting to a hospital birth setting. When complications develop during labor or in the immediate postpartum period, access to a higher level facility with appropriate medical technology is an essential component in the achievement of good outcomes for mother and baby. Although the mother and her family are prepared in advance for the possibility of the need to transfer to a hospital setting during labor, it is often an emotionally difficult transition. The Society of Obstetricians and Gynaecologists of Canada summarizes this well in their Maternal Transport Policy:

“All care providers involved in maternal transport must be attentive to the emotional needs of the woman and her family during what is frequently a frightening and sometimes grief-filled experience. The establishment of a support system is important to the woman’s well-being. Even in emergency situations, it is important not to neglect the principles of family-centred care.”

(SOGC 2005, p. 1)

It is clearly in the mutual interest of both the transferring midwife and the receiving physician to avoid poor outcomes which could potentially lead to malpractice suits. This is likely a concern for the receiving hospital staff and physician, who typically have never met the family and may have little or no knowledge of the midwife or her practice guidelines. Unobstructed admittance, good communication, continuity of care, as well as appropriate and timely medical attention, all have the potential to improve maternal and neonatal outcomes and client satisfaction. The clinical situation and the attitudes of the mother and her family, the physician, and the midwife all play a part in how the home to hospital transfer proceeds. This document will provide background regarding licensed midwives, define expectations, and enhance the flow of information, ultimately allowing transfers to proceed more smoothly, efficiently, and safely.

## 2. **BACKGROUND ON LICENSED MIDWIVES**

Washington State Department of Health defines two types of legal midwifery practice: Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs). Another credential sometimes used is Certified Professional Midwife (CPM). CPMs have met the standards for certification set by the

North American Registry of Midwives (NARM) but may or may not have passed the licensure exam in Washington State. Many LMs are also CPMs, but the credential of CPM is not equivalent to licensure in Washington State.

Although some out-of-hospital deliveries are attended by CNMs, the vast majority in Washington State are attended by LMs. Most LMs in this state have completed 2 years of prerequisites followed by a 3-year program which includes relevant curriculum, nursing skills, and attendance at 100 births, prior to passing an examination provided by the North American Registry of Midwives (NARM) as well as an additional test specific to Washington State practice issues. LMs are regulated under RCW 18.50 and usually have independent practices, attending deliveries in homes and/or free-standing birth centers. LMs are authorized to obtain and administer the following:

<b>MATERNAL</b>	<b>NEWBORN</b>
antibiotics for intrapartum GBS prophylaxis per current CDC guidelines	newborn ophthalmic ointment
anti-hemorrhagic drugs to control postpartum hemorrhage (oxytocin, misoprostol, methylergonovine maleate, and Hemabate)	newborn Vitamin K injection
local anesthetic for perineal repair	HBIG
terbutaline (pending transport)	HBV
epinephrine (pending transport)	
magnesium sulfate (pending transport)	
MMR vaccine	
RhoGAM	

LMs may purchase and use the following devices: dopplers, syringes, needles, phlebotomy equipment, suture, urinary catheters, IV equipment, airway suction, electronic fetal monitoring devices, oxygen, neonatal and adult resuscitation equipment, glucometers, centrifuges, and may

prescribe breast pumps, compression stockings/belts, diaphragms, and cervical caps (WAC 246-834-250).

The state professional association for LMs is the Midwives' Association of Washington State (MAWS). A requirement of membership is participation in the MAWS QA/QI program of formal incident and peer review. LMs are able to contract with a variety of health insurance plans, including Medicaid. Professional liability insurance is available through a joint underwriting association.

### **3. INDICATIONS FOR TRANSPORT**

An essential component of safe out-of-hospital maternity care is access to a higher level facility when indicated. It is important to remember that the vast majority of LM transports are still “normal” OB cases, resulting in vaginal delivery, the most likely reasons for transport being a combination of prolonged labor, request for pain relief, and maternal exhaustion.

LMs are trained to care for women having normal pregnancies and labors. The Washington State law that governs the practice of midwifery states that “It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant” (RCW 18.50). When complications are detected before the onset of labor, early consultation or referral is ideal. It is always preferable to avoid intrapartum emergency transport, and most transports occur long before the situation becomes emergent. A recent study by Kenneth C. Johnson and Betty-Anne Daviss, “Outcomes of planned home births with certified professional midwives: large prospective study in North America” published in the British Medical Journal in June of 2005, informs this discussion, providing useful statistics gathered from 5418 planned out-of-hospital births in North America in the year 2000. The study confirms that “Planned home birth for low risk women in North America using certified professional midwives was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality to that of low risk hospital births in the United States” (Johnson and Daviss 2005, p. 1416). The study reported a 3.7% cesarean section rate, while the national average for singleton, vertex term women in the year 2000 was 19.0% (Johnson and

Daviss 2005, p. 1419). The authors summarize the incidence of the various indications for transfer in the following paragraph:

*Of the 5418 women, 655 (12.1%) were transferred to hospital intrapartum or postpartum ... Five out of every six women transferred were transferred before delivery, half (51.2%) for failure to progress, pain relief or exhaustion. After delivery, 1.3% of mothers and 0.7% of newborns were transferred to hospital, most commonly for maternal haemorrhage (0.6% of total births), retained placenta (0.5%), or respiratory problems in the newborn (0.6%). The midwife considered the transfer urgent in 3.4% of intended home births. Transfers were four times as common among primiparous women (25.1%) as among multiparous women (6.3%) but urgent transfers were only twice as common among primiparous women (5.1%) as among multiparous women (2.6%). (Johnson and Daviss 2005, p. 1417)*

**Table 1 – INDICATIONS FOR INTRAPARTUM TRANSFERS:**

<b>INDICATION</b>	<b>% OF ALL BIRTHS<sup>1</sup></b>	<b>% OF ALL TRANSFERS<sup>2</sup></b>
<b>INTRAPARTUM</b>		
Failure to progress in 1 <sup>st</sup> stage	4.2%	34.7%
Failure to progress in 2 <sup>nd</sup> stage	1.5%	12.2%
Pain relief	2.2%	18.2%
Maternal exhaustion	2.1%	17.1%
Malpresentation	1.7%	14.4%
Thick meconium	0.9%	7.5%
Sustained fetal distress	0.9%	7.5%
Baby's condition	0.4%	3.2%
Prolonged or premature ROM	0.4%	2.9%
Placenta abruption or placenta previa	0.2%	1.5%
Hemorrhage	0.1%	1.1%
Pre-eclampsia or hypertension	0.2%	2.0%
Cord prolapse	0.1%	0.9%
Breech	0.1%	0.5%
Other	0.3%	2.6%
<b>POSTPARTUM</b>		
<b>Newborn:</b>		
Respiratory problems	0.6%	5.0%
Evaluation of anomalies	0.1%	1.2%
Other reasons	0.3%	2.6%
<b>Maternal:</b>		
Hemorrhage	0.6%	5.2%
Retained placenta	0.5%	4.3%
Suturing or repair of tears	0.2%	2.1%
Maternal exhaustion	0.1%	0.6%
Other reasons	0.1%	1.2%

1. Source: Johnson and Daviss 2005, p. 1419 (Table 2 “Transfers to hospital among 5418 women intending home births with a certified professional midwife in the United States, 2000, according to timing, urgency, and reasons”)

2. These percentages were derived by simply dividing the number transferred for a particular reason by the total number transferred (n=655). This column adds up to more than 100% as both primary and secondary reasons (if reported) for transfer to hospital are presented. It is intended to give an overview of the likelihood of specific clinical situations being present during a transfer.

#### **4. COMMUNICATION and EXPECTATIONS**

The circumstances surrounding an intrapartum or postpartum transport of a planned out-of-hospital birth heighten the need for clear and respectful communication among the transferring midwife, receiving physician, hospital personnel, and the client. The midwife should do everything possible to promote understanding of any relevant clinical information. The “Transport Summary Form” provided by the MAWS Transport Policy Committee can be utilized to provide a quick reference for hospital personnel, but verbal communication is the primary means of communication.

##### **4.1. IN GENERAL, THE HOSPITAL CAN EXPECT THE FOLLOWING:**

The midwife will discuss the need for transport with the client and her family, allowing adequate opportunity for questions and concerns, time permitting. The midwife will also prepare her client for any anticipated hospital procedures. The midwife will strive for respectful and collegial interactions with hospital providers. During such a transfer of care, the midwife will generally interface with the receiving hospital in the following ways:

1. A telephone call to the nursing supervisor or labor and delivery charge nurse notifying him/her of incoming transfer, providing clear, concise clinical information about the mother and/or baby.
2. A telephone call to the accepting practitioner will include the reasons for transport, background clinical information, the condition of the mother and/or baby, the planned mode of transport, and the expected time/location of arrival.
3. If the transfer is emergent, a telephone call will be made to notify EMS of urgent need for transport, including the above information, and any anticipated interventions necessary for stabilization during transfer.
4. The midwife will either provide photocopies of the relevant medical records or will provide originals which can be copied by the hospital and returned to the midwife.
5. If possible, the midwife will accompany the client to the hospital to facilitate a smooth transfer of care and provide ongoing support for the client. This continuity of care has the potential to enhance the professional relationship between midwives and hospital practitioners and greatly improve client satisfaction with care.

6. After the delivery, follow-up communication with the hospital practitioner(s) will ideally occur. This allows for feedback and further strengthens relationships.

4.2. **IN GENERAL THE MIDWIFE CAN EXPECT THE FOLLOWING:**

1. Recognition of the midwife as a primary care practitioner who has transferred to a higher level facility due to a need for advanced resources and skilled personnel. The goal is respectful, collegial interaction between hospital personnel and the midwife.
2. Hospital staff will provide safe, respectful care to the client and attempt to integrate the family's preferences with any necessary interventions.
3. The hospital practitioner(s) and the midwife will coordinate a schedule of follow-up care for mother and/or baby.
4. After the delivery, relevant medical records are sent to the midwife.

**5. ONGOING PERFORMANCE EVALUATIONS and FOLLOW UP**

Ongoing communication benefits of all parties. Case review may at times be appropriate, and all parties would, hopefully, be open to this. It is a primary goal to have an environment of collegial dialogue and mutual feedback which would contribute to seamless coordination of care across settings.

**6. SOURCES**

Chapter 18.50 RCW (Revised Code of Washington) – Midwifery

Chapter 246-834-250 WAC (Washington Administrative Code) – Midwives: Legend Drugs and Devices

Johnson, Kenneth, C. and Daviss, Betty-Anne. "Outcomes of planned home births with certified professional midwives: large prospective study in North America" British Medical Journal. 2005; 330:1416.

Society of Obstetricians and Gynaecologists of Canada (SOGC). Maternal Transport Policy. No 165, October 2005.

## Appendix C

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### Planned Out-of-Hospital Birth Transport

#### Quality Improvement Interview Questionnaire Sample

Date of Transport:

Transferring Midwife's Name:

Receiving Physician's Name:

Receiving Nurse's Name:

1. What was/were the indication(s) for transport?
2. Describe how the transport occurred. What were the steps? (For example, did the mother arrive at the hospital ER? Did midwife call ahead? Did EMS transport? etc.)
3. Describe the hospital course, including the delivery, applicable. Please include a brief summary of progress.
4. Do you have any concerns about the timeliness of patient transport, or of hospital care provided?

If so, what are your concerns?

How might they be handled differently?

5. Do you have any concerns about communication between providers before transport, during delivery or postpartum? (Probe for concerns about respect, sense of trust, and expectations)

If so, what are your concerns?

How might this have been handled differently?

6. Do you have any concerns about communication between the patient and providers before transport, during delivery or postpartum? (Probe for concerns about respect, sense of trust, and expectations)

If so, what are your concerns?

How might they be handled differently?

7. How well do you feel the midwife, EMS staff and hospital staff worked together, and jointly supported/assisted the mother? (Probe for concerns about patient records, patient/LM consultation in decision-making)

8. Do you have any concerns about postpartum care and follow-up?

If so, what are your concerns?

How might they be handled differently?

9. Which of these procedures were involved in the patient's care?

**Maternal**

Pain relief

Vacuum

Cesarean

Pitocin

Forceps

Transfusion

Other:

**Infant**

NICU admission

Other:

10. Additional comments?

## Appendix D

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### Planned Out of Hospital Birth Transfer Quality Improvement Project

#### Annual Transfer Summary Sample

Reporter

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Today's date: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Reporting Year: \_\_\_\_\_

Number of transfers received from January 1 through Dec 31 of reporting year: \_\_\_\_\_

Number of transfers for whom entire team (Attending physician, OB nurse, Pediatrician, Midwife, Mother) were interviewed/completed written survey: \_\_\_\_\_

Number of transfers for whom only part of team interviewed/completed/written survey: \_\_\_\_\_

General summary of transfer experiences:

Please do not include specific identifying information, but describe the overall sense of how well the program is working in terms of:

- a) infant and maternal health
- b) ease of communication/care transfer from midwife to hospital staff intrapartum
- c) ease of communication/care transfer from hospital staff to midwife postpartum
- d) maternal satisfaction
- e) provider satisfaction (from all perspectives)
- f) resource use

Please describe any concerns/barriers identified during the interviews.

Please describe any actions taken to address these concerns/barriers.

Please describe any other actions taken to improve transports.

Please describe any additional technical assistance needed from the Licensed Midwife/Physician Workgroup or the Washington State Perinatal Collaborative: