Oregon Perinatal Collaborative

Oregon Community Birth Transfer Partnership

Transfer Improvement Toolkit

A Collaborative Quality Improvement Initiative

Created March 2021

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH AIM

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Acknowledgment

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We are grateful to the over 100 people who completed the CBTP survey, as well as the 14 participants of our focus groups who generously shared their experiences and feedback.

Oregon Community Birth Transfer Partnership

Community Birth Transfer Improvement Guide

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Introduction

Thank you for your interest in the Oregon Community Birth Transfer Partnership (CBTP), a quality improvement program to increase safety and both patient and provider satisfaction in community birth to hospital transfers. This toolkit is intended for Oregon hospitals and community midwives who want to improve transfers from planned home and birth center births to hospitals. We hope the information and tools provided here will contribute to smooth collaboration and transfer between community midwives and hospitals across Oregon and beyond.

The first step for a hospital to join the CBTP is to review this toolkit with clinical and administrative staff in your institution (include labor and delivery, well newborn/pediatric unit, and neonatal intensive care unit as applicable) and schedule an initial presentation from the CBTP. To schedule a presentation, please contact opc@ohsu.edu.

Our Mission

To realize a high performing, mutually respectful and integrated healthcare system that optimizes patient/client safety and experience and increases community midwife and hospital collaboration when transfer occurs from community birth to hospital settings.

Goals

- Eliminate barriers to safe and timely transfers from planned community birth settings to in hospital care settings.
- Partner with patients/consumers in advocacy and quality improvement efforts related to safe transfers of care.
- Promote interprofessional collaboration to encourage productive, collegial relationships grounded in respectful, patient/client-centered care.
- Expand skills, knowledge, and relationships through meaningful interprofessional case reviews and continuing education.

We know that community transfers can be collaborative and safe for all involved.

The birthing people who participated in our community birth transfer survey and focus groups who had good transfer experiences remind us of what is possible:

"Honestly the whole experience was way more pleasant than I anticipated…. I felt like there was no judgment from any of the staff members, and that they were truly acting in our best interest. It seemed like they tried everything they could to preserve a vaginal birth, and they were empathetic when deciding to move to a c-section. They also called my midwives to discuss their rationale."

-CBTP survey response

How to use this toolkit

This toolkit provides key information on community birth and midwife to hospital transfers and walks the reader through a step-by-step process to improve community birth transfers including:

1. Initial provider and staff education
2. Formation of a hospital-community transfer improvement committee
3. Implementation of transfer improvement protocols and materials
4. Annual benchmarking and planning
5. Additional transfer improvement projects

For each section, there is an overview, essential steps to complete each section, and recommended education. The Oregon Perinatal Collaborative has selected key resources from existing toolkits that may be adopted and adapted by each hospital. This is not an exhaustive compilation of tools; it does, however, provide the core components needed for a facility to successfully implement the community birth transfer improvement toolkit and meet the goals of the OPC Community Birth Transfer Partnership. We encourage providers and hospitals to review and utilize the resources from the following organizations in addition, as they each offer valuable tools and guidance for improving community birth transfers.

Key references for this toolkit

Smooth Transitions
Washington state-based quality improvement program enhancing the safety community birth to hospital transfers
https://www.qualityhealth.org/smoothtransitions/

Home Birth Summit
Consensus materials developed in multidisciplinary stakeholder summits including Best Practice Transfer Guidelines
https://www.homebirthsummit.org/task-forces/collaboration/

Alliance for Innovation on Maternal Health
Patients safety bundles to reduce preventable maternal mortality and severe morbidity
https://safehealthcareforeverywoman.org/aim-program/

Background

Planned home births and birth center births (also known as community births) are relatively common in Oregon compared to most of the United States. Four percent of births in Oregon and 1.6 percent of births in the US overall are planned community births[1]. In Oregon, community births are attended by Licensed Direct-Entry Midwives (47.2%), Certified Nurse Midwives (29.8%), Naturopathic Physicians (8.2%), and traditional unlicensed midwives (12.2%)[2]. Additionally, 40 to 60 births per year are planned, unassisted births where the family intentionally chooses to have no midwife or trained attendant present at the birth[2]. Community births in the US have been increasing since 2004 and the trend is expected to continue[1].

Families choose community birth for a number of reasons including: desire for a natural, unmedicated birth; individualized, relationship-based care; desire to avoid unnecessary interventions; longer appointments with a focus on education, nutrition, and preventive care; informed choice based model of care; participation in their own care; direct access to care provider (a midwife is available by phone 24-7); continuity of care (the same, familiar midwife, or group of midwives, will be with them through pregnancy, birth and postpartum); fear of, or negative experiences with, the hospital or medical care; religious or cultural reasons; and desire for control over their birth.

Families choosing a community birth come from all walks of life, and all races, religions, and class backgrounds though in most parts of the country community birth is less accessible to people of color and low-income people[1,3]. Families choosing a community birth tend to be well educated about health care options and expect to be active participants in their care[4, 5]. Families choosing a community birth are more likely than the general population to:

- Believe that birth is a natural and normal body process, not a sickness
- See the birthing person as the center of decision-making in pregnancy and birth
- Want in-depth information about any test or procedure.
- Question routine procedures and practices
- Object to interventions unless they understand them to be truly necessary

Planned community births unfold normally at home or birth center most of the time but part of what makes community birth safe is the ability to transfer to a hospital when it does not. Hospital transfer occurs in 15% of planned community births in Oregon[2]. These transfers happen when pain medication or labor augmentation is needed or when

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[1] MacDorman, M. F., & Declercq, E. (2019). Trends and state variations in out-of-hospital births in the United States, 2004-2017. *Birth*, *46*(2), 279-288.

[2] Oregon Center for Health Statistics. (2020). Planned place of birth by selected demographic and medical characteristics, Oregon occurrence births, 2012-2019. Accessed from: https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregonbirthsbyplannedplaceofbirth2012-2019/PlannedPlaceofBirthDashboard

[3] 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*(1), 17-27.

[4] Bernhard, C., Zielinski, R., Ackerson, K., & English, J. (2014). Home birth after hospital birth: women's choices and reflections. *Journal of midwifery & women's health*, *59*(2), 160-166.

[5] Boucher, D., Bennett, C., McFarlin, B., & Freeze, R. (2009). Staying home to give birth: why women in the United States choose home birth. *Journal of midwifery & women's health*, *54*(2), 119-126.

complications arise. The large majority of transfers are not emergencies and transport happens by private care, without the involvement of emergency medical services (EMS). The most common reasons for transport are maternal exhaustion or prolonged labor and the birthing person is going to the hospital for an epidural and/or labor augmentation. In cases when emergency transport by ambulance is needed, the most common reasons are fetal distress during labor; postpartum hemorrhage that is unresponsive to the medications and treatments available to the community midwife; or newborn respiratory distress or complex resuscitation.

Families who have planned a community birth are often deeply disappointed by the need to transfer to the hospital and will need sensitive care during the transition from the birth they planned to a medical environment. Transfer to the hospital is not a "failed home birth" or "failed birth center birth," it is safe and appropriate care for those births that need a higher level of care.

Midwife attended community birth in Oregon is a safe option for low-risk birthing people and babies. The Oregon Center for Health Statistics collects data on planned place of birth and provider type and also tracks the outcomes of planned community births that transferred to the hospital so that all community birth outcomes are reflected in the data. The 2019 cesarean section rate for planned community births was 9.1% in comparison to 34.2% for planned hospital births[2].There is no significant difference between the rates of maternal transfusion for planned community births and planned hospital births[2]. For planned community births in 2019, the rate of newborn NICU admission was 2.3% in comparison to 8.6% for term hospital births[2]. The midwife-attended community birth perinatal mortality rate is 0.84/1,000 compared to the planned hospital birth rate of 1.58/1,000 for 2015-2018, the most recent years for which data is available[2]. Most community births in Oregon are attended by midwives who are licensed and regulated by a licensing board. The education and clinical training routes of the three types of licensed midwives have differences but all three have robust clinical and educational requirements (see Appendix E for a comparison of the credentials).

When transfer is needed, Midwives, EMS, and receiving hospital providers function as a care team whether we recognize it or not. The birthing person and/or the baby are cared for by midwives, EMS, and receiving providers (the physicians, nurse-midwives, and nurses in the hospital) in turn. When we work together, we can improve outcomes and the experience of care for mothers and babies. Working as a team like this requires clear communication, understanding of each of our roles, and coordination of care. But few providers have received specific training on seamless community birth to hospital transfer and there is a long history of tension between hospital providers and community midwives. Midwives, EMS, and receiving hospital providers all want excellent, safe care for mothers and babies but we face a number of barriers to working collaboratively together:

- We often have little information about each other and may have misinformation or bias.
- We often have little contact with each other outside of stressful emergency situations.
- There are major differences in practice culture between birthing families, midwives, EMS, and receiving hospital providers and sometimes those cultures come into conflict.
- There are structural, system-level problems that prevent midwives, EMS, and receiving hospital providers from working collaboratively together.

Research Review

The body of research on community birth to hospital transfers in the US provides clear information about existing tensions and barriers as well best practices for moving towards smooth and safe collaboration. Below are summarized

five landmark publications in the medical literature that capture the significant opportunities and challenges in our current system.

Cheyney, Everson, and Burcher's 2014 study on divisions about home birth provided illustration of the tensions between home birth midwives and hospital providers and described areas for improvement. The qualitative research involved interviews with home birth midwives, obstetricians, Certified Nurse-Midwives (CNMs), and perinatologists about communication and collaboration during memorable transfer experiences. In the interviews with hospital providers, the three key themes were: "(a) the belief that home delivery is substantially more dangerous than current studies suggest; (b) the experiences of fear and frustration generated when physicians are forced to assume the risk of caring for another provider's patient; and (c) challenges related to charting and interprofessional communication."

In contrast, the three key themes from the interviews with midwives were: (a) the defense of more holistic and co-negotiated constructs of risk in midwifery models of care; (b) physicians' tendencies to judge Direct-Entry Midwives (DEMs) by "the exception, rather than the rule"; and (c) the failure of physicians to take responsibility for their roles in poor state and national maternal–child health outcomes." Community midwives expressed concern that blame and misunderstanding of home birth and midwives was "so entrenched that it could be insurmountable." The authors shared three recommendations from their research for improving collaboration and communication during community birth transfers:

1. Hospital providers should treat community midwives as respected colleagues
2. Hospital providers should not assume that a transferring patient will decline hospital procedures
3. Community midwives should focus on timely transport and clear charting[6]

A 2014 review of the research on transfer from planned home birth to hospital in the US describes models that have improved collaboration. It outlines the best practice guidelines for transfers developed by the first and second Home Birth Summits in 2011 and 2013[7]. This research describes the strong and divided opinions about home birth as well as regulatory restrictions that impede the integration of community birth midwives. It goes on to describe the consensus-building work of the Home Birth Summits, during which midwives, physicians, nurses, consumers, researchers, insurers, lawyers, and other stakeholders met to improve the safety and accessibility of home birth. These stakeholders created the Best Practice Transfer Guidelines which covers model practices for community midwives and hospital providers and staff as well as recommendations for quality improvement and policy development (see Appendix A for the full guidelines).

The guidelines emphasize prenatal preparation for transfer, clear communication between providers, and coordination of care. The article goes on to describe the work of the Northern New England Perinatal Quality Improvement Network (NNEPQIN) which includes state community midwife organizations in its confidential review board so that all providers and places of birth are included in quality improvement review. It also describes Smooth Transitions, the Washington state comprehensive community birth transfer improvement program that was the first statewide program developed through a perinatal collaborative model. Finally, it describes the long-term work of the University of New Mexico Hospital to improve community birth transfers through collaborative care and interprofessional education[7].

[6] Cheyney, M., Everson, C., & Burcher, P. (2014). Homebirth transfers in the United States: narratives of risk, fear, and mutual accommodation. *Qualitative health research*, *24*(4), 443-456.

[7] Vedam, S., Leeman, L., Cheyney, M., Fisher, T. J., Myers, S., Low, L. K., & Ruhl, C. (2014). Transfer from planned home birth to hospital: improving interprofessional collaboration. *Journal of midwifery & women's health*, *59*(6), 624-634.

In a 2015 commentary on making home birth safer through collaboration, Duncan Nielson describes Legacy Health System's process of working to improve relationships and transfers with community midwives in Oregon. The commentary emphasizes that community birth transfer improvement is important for all providers and institutions, regardless of opinions or beliefs about community birth and midwives, because it is part of providing safe care for mothers and babies. It outlines the successes Legacy Health System had with education on community birth transfers for hospital staff, implementation of an obstetrician hospitalist program and midwife-to-midwife transfers. The hospital found that the use of joint midwife-hospital case review for indicated cases led to improvements in communication with community midwives and community midwife transfer decisions[8].

In their 2018 study mapping the integration of midwives in the US, Vedam et al. note that "Poor coordination of care across providers and birth settings has been associated with adverse maternal-newborn outcomes."[9] They created a Midwifery Integration and Scoring System (MISS) tool to measured 110 factors of regulation and practice environment for midwives across the US and found that states with higher MISS scores had better outcomes for mothers and newborns. States with higher MISS scores had "significantly higher rates of vaginal delivery, vaginal birth after cesarean, and breastfeeding, and significantly lower rates of cesarean, preterm birth, low birth weight infants, and neonatal death." This research indicates that increasing integration of midwives may be a key strategy to improving birth outcomes, especially for BIPOC families, at the state level[8].

Caughey and Cheyney's 2019 review of the research on community birth calls for greater collaboration across maternity and newborn care systems to improve outcomes[10]. They note that countries with better outcomes, and higher rates of community birth, have well integrated systems of care and guidelines for appropriate care at each level and for transfer across the systems according to risk. They describe that systems of midwife-led care for low-risk pregnancies are common in many countries in Europe. They also note that planned community birth is consistently associated with better outcomes for birthing people and no greater risk for babies than hospital birth when midwives are well integrated but that there is some evidence for increased risk for poor neonatal outcomes in places where community midwives are not well integrated in the health system. They recommend systems level approaches to improve integration of community midwives and collaboration between community midwives and hospital systems[9].

This research informed our emphasis on adopting best practice guidelines, supporting interprofessional collaboration and education, and increasing integration of midwives in the Oregon Community Birth Transfer Partnership.

[8] Neilson, D. (2015). Making home birth safer in the United States through strategic collaboration: the legacy health system experience. *Birth*, *42*(4), 287-289.

[9] Vedam, S., Stoll, K., MacDorman, M., Declercq, E., Cramer, R., Cheyney, M., ... & Powell Kennedy, H. (2018). Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. *PloS one*, *13*(2), e0192523.

[10] Caughey, A. B., & Cheyney, M. (2019). Home and birth center birth in the United States: time for greater collaboration across models of care. *Obstetrics & Gynecology*, *133*(5), 1033-1050.

Foundational Feedback from Community Birth Transfers

Family/consumer feedback is essential for effective quality improvement in community birth transfers. One of our CBTP goals is to increase consumer engagement in quality improvement efforts related to safe transfers of care so we built that engagement into the formation of this program through surveys, focus groups, and direct involvement on committees.

The CBTP Family/Consumer Engagement Workgroup created a survey and a focus group guide to collect information from birthing parents who experienced a transfer from a planned home birth or birth center birth in Oregon about their transfer experiences and their feedback for quality improvement. 119 birthing parents responded to the initial survey and 14 birthing parents participated in the focus groups. We then used the results of this research to shape each element of the Community Birth Transfer Partnership quality improvement program.

Key Findings

Birthing parents who responded to the survey or participated in the focus groups were pleased to be asked about their transfer experiences and to be included in efforts for improvement. They provided clear information about what works well during community birth transfers and what needs to change. The same core themes emerged from both the surveys and the focus groups.

Respect

Birthing people want to be treated with respect in all aspects of care during a transfer. When focus group participants were asked what respect means to them they made it clear that they want to be listened to, included as a full and active partner in their care, treated with kindness, and valued as a unique human being having an emotional, physical, social, and spiritual birthing experience. The need to be listened to and believed was especially important to Black, Indigenous, and People of Color (BIPOC) respondents and participants and was framed as a prerequisite for any sense of safety in the hospital setting. BIPOC participants also wanted hospital staff to understand that choosing natural birth can be a deep cultural value that requires respect and consideration.

[Respect means] "being truly listened to… my preferences and values being taken into account… my voice being the authority, the ultimate authority in the birth situation."

"I think that the medical community, hospitals and clinics specifically need to have an awareness that some people's preference for more like natural or low-intervention birth is cultural and not just like some hippie new age movement. That it's actually a return to roots and actually very important on like a spiritual level for people."

Community Midwife as Support and Advocate

Birthing parents wanted their community midwife with them and experienced her presence as supportive, comforting, and protective. They relied on their community midwife for a sense of security in a challenging situation and some described their community midwife as an interpreter between the two worlds/cultures/approaches. They were particularly positive in their description of their transfer experience when they felt like their midwife was included in collaborative care.

"I would not have felt safe or in control without my midwife there. Period."

"I had wonderful continuity of care, as my homebirth midwife remained my care provider at the hospital. I felt respected and supported by all of the providers we saw, and I was allowed to go at my own pace without feeling rushed or pressured into any interventions or decisions I wasn't ready for. I believe having my midwife stay with me contributed to this experience."

Informed Choice

Birthing people want full and consistent informed choice at the hospital during community birth transfers. They compared the level of informed choice in the hospital with what they were accustomed to in midwifery care unfavorably. Birthing parents want information on risks, benefits, and alternatives for all treatments including common interventions like epidurals. They also want time to consider their options and respect for their decisions without continued attempts to persuade them if they chose something other than what was recommended.

"At home, I was very much a part of every decision that we made. I am capable of being a member of a decision-making team like it's my life, it's my child's life. And, it felt like at the hospital, instead of being treated like the mother of my child, I was also being treated like a child."

Preparation for Transfer

Birthing people agreed that community midwives need to improve preparation for the possibility of hospital transfer. They want to see midwives discuss transfer on more occasions, provide information on transfer in different forms (such as written handouts), and encourage all clients to pack a hospital bag. Many birthing people also acknowledged that their midwife had attempted to prepare them for hospital transfer but they were in denial that it could happen to them and were not open to the information.

"I felt prepared in the sense that I trusted my midwife 100% and felt confident in that I would be okay and she knew when and how to make that call, but mentally I was not. But I know a large piece of that was me not wanting to 'put it out in the universe' because of a core belief I hold about birth not having to be a medical event."

Good Care

Birthing parents clearly defined what good care during a community birth transfer means to them. Much of their conception of good care centered around respect, slowing down, listening, and offering kindness. They liked it when providers took the time to listen, provide explanation, and give space and time to process major decisions. Descriptions of good care were often defined by collaboration between the hospital and the community midwife. BIPOC participants emphasized that each birthing person is unique and needs individualized care.

"Amazing! The obstetrician really respected my midwife's knowledge and let her be actively involved in helping me labor. They collaborated and explained things together for me. I was so impressed, pleased and grateful."

"The hospital was respectful to me and really listened and did their best to consider and accommodate my needs."

Mistreatment and Abuse

A significant number of birthing parents in the survey and focus groups had experienced mistreatment or abuse in the hospital during their transfer experience. Threats, intimidation, and coercion were the most common forms of mistreatment experienced. Birthing people who experiences mistreatment or abuse emphasized that these experiences affected them for months and years and providers need to understand how large their impact can be. Experiences of threat and coercion undermined any sense of control, respect, or ability to make informed choices.

"During pushing the OBGyn gave an open ended threat in the way of saying 'if you don't push baby out in the next push.....', which was not an appropriate way for expressing urgency or knowledge of the step that would need to be taken next."

"The hospital treated myself my midwife, my friends and family like absolute garbage."

"She gave me an episiotomy at the last second without my consent"

Recommendations for Improvement

Birthing parents gave consistent recommendations for improving community birth transfers both at the provider and system levels. The following is a summary of the most frequently occurring recommendations divided into areas for improvement. The complete recommendations can be found in the CBTP survey and focus group reports in Appendix C.

Recommendations to improve outcomes for BIPOC families

- Listen to women. Listen to mothers
- Partner with families
- Recognize that birth is physical, emotional, and spiritual
- Work towards collaborative co-care between community midwives and hospital providers
- Provide public education about birth options, midwives, and community birth
- Provide training for hospital providers on cultural awareness and Black mortality/morbidity
- Mandate universal insurance coverage of midwives and doulas
- Increase OHP payment for doulas

Recommendations for Community Midwives

- Community midwives should increase and improve preparation for hospital transfers
    - Encourage preregistration at the hospital
    - Encourage packing a hospital bag
    - Use handouts for hospital transfer education
- Ask for feedback from clients who transfer and adjust practices based on feedback

Recommendations for Hospital Staff

- Treat the birthing person like a partner in their care
- Welcome and include the community midwife
- Respect birthing parent choices about maternity and newborn care
- Validate the birthing person's experience
- Take more time to explain procedures
- Remove the stigma around planning a home birth
- Don't rush. Slow down.

Recommendations for Hospital Systems

- Provide education for hospital staff on midwives and community birth
- Provide training for staff on informed choice, respectful care, and empathy
- Create clear communication protocols for incoming transfers
- Create protocols so that community birth transfers can go straight to labor and delivery (L&D) and not the emergency department (ED)
- Improve inpatient postpartum care with a focus on respect, informed choice, and minimizing disruptions during rest
- Increase postpartum care and support after discharge for all families
- Coordinate discharge and follow-up care with the community midwife

Collaborative Recommendations

- Hospital providers and community meet regularly to build relationships
- Community midwives and hospital providers work on clear communication about level of urgency of care
- Community midwives and hospital work together on communication with EMS

We are grateful for the expertise of all of the birthing parents who contributed to the creation of the CBTP quality improvement program through their participation in CBTP committees, responses to the survey, and participation in the focus groups. Their valuable input enabled us to create a responsive program that can meet the needs of birthing families in Oregon.

This foundational work has informed how we framed the elements of this toolkit but it is not complete. The CBTP will continue to use the survey to solicit birthing people's feedback and experiences during community birth transfers. We encourage providers and institutions to make the survey available to all community transfer patients. See Appendix C for the full Community Birth Transfer Survey and Focus Group reports.

Community Birth Transfer Partnership Transfer Improvement Program

Any Oregon hospital can join the Community Birth Transfer Partnership after an initial presentation and assessment. The CBTP offers ongoing support for hospitals and community midwives as they work through the steps of transfer improvement.

How to Join

- [ ] Review this toolkit within your hospital maternity and newborn care leadership teams.
- [ ] Contact opc@ohsu.edu to let us know of your hospital's interest. We will conduct a pre-program interview to understand the hospital and community's needs.
- [ ] Schedule a Community Birth Transfer Partnership presentation. This initial presentation should include nurse leaders, maternity and newborn providers, quality improvement staff, ED staff, and hospital administration representatives. The presentation will be one hour in length with one physician and one community midwife presenter with time for questions.
- [ ] Formally commit to joining the CBTP. An enrollment form will be made available to you following the CBTP initial presentation.

Initial Steps for CBTP Hospitals

After submitting your enrollment form, your initial steps:

☐ Identify one or two leaders for your hospital-community transfer improvement committee who will schedule and facilitate meetings.

☐ Recruit participants from the following areas:

Internal	External
• Obstetric care providers • Neonatal care providers • Anesthesia providers • L&D nursing and leadership • ED representative if your institution prohibits transfer directly to L&D	• Local community midwives (CBTP leaders can assist with identification and outreach) • Local emergency medical services (EMS) representatives

☐ Schedule and hold an initial meeting. The purpose of this meeting is to get to know each other, share about areas of transfer improvement you would like to focus on, and make a plan for working together

☐ Form a Hospital-Community Transfer Improvement Committee and make a plan to meet 2-3 times a year to work on transfer improvement. The initial meeting should engage participants and request that attendees commit to participation in this ongoing committee work. This committee should include physician, CNM, nurse, EMS, and community midwife representatives.

☐ Begin Hospital-Community Transfer Improvement Committee work

The Initial Hospital-Community Transfer Improvement Committee Meeting

In this first meeting it is important to take time for participants to get to know each other and to acknowledge the discomfort and mistrust that may be present if there is a history of stressful transfer experiences in this community. A representative of the CBTP is available to facilitate this initial committee meeting if desired by the hospital or community midwives. We recommend CBTP facilitation of the initial meeting particularly if the relationship between the hospital and community midwives has been fraught.

The purpose of this meeting is to get to know each other, learn about the CBTP, share about areas of transfer improvement you would like to focus on, and make a plan for working together. We recommend the initial meeting include:

- ☐ Introductions
- ☐ Background information on hospital and community midwives
- ☐ Mission and Goals of Oregon Community Birth Transfer Partnership
- ☐ Oregon Community Birth Transfer Partnership Steps
- ☐ Set up ground rules for the meetings
- ☐ Areas of concern / Areas for improvement
- ☐ Planning for future meetings

Please see Appendix B for a sample initial meeting agenda.

Ongoing steps for Community Birth Transfer Partnership Hospitals

The ultimate goal of the Hospital-Community Transfer Improvement Committee is to not only improve clinical outcomes but also to improve relationships and family/consumer and provider experiences. This work requires regular meetings and ongoing assessments of community birth transfers. Below are suggested elements of ongoing community birth transfer improvement work:

- ☐ Hold Hospital-Community Transfer Improvement Committee meetings 2-3 times a year
- ☐ Recruit family/consumer representatives to participate in the committee
- ☐ Implement use of CBTP survey with each community birth transfer patient
- ☐ Implement use of Home Birth maternal and newborn transfer forms
- ☐ Create protocols or best practice guidelines for transfers
- ☐ Examine specific recommendations for improving transfers for BIPOC families (see CBTP Focus Group Report in Appendix C)
- ☐ Participate in annual data benchmarking and send annual report to CBTP
- ☐ Carry out annual assessment of transfers and planning for further improvement work

Objectives for Hospital-Community Transfer Improvement Committee Work

Individual Hospital-Community Transfer Improvement Committees will choose their own priorities for transfer improvement work. Each hospital and community will have its own considerations and constraints. We encourage transfer improvement committees to begin with smaller projects where there is agreement on the committee and institutional support in order to optimize successes. The committee can then build on success over time and approach the more challenging areas for improvement in that hospital and community. The following are project areas that Hospital-Community Transfer Improvement Committees may focus on:

Joint Projects

- Adopt use of Home Birth Summit maternal and newborn transfer forms (see Appendix A)
    - Collect feedback for future edits to forms
- Create transfer protocol
- Create process for joint peer review for challenging transfers
- Hold annual or more frequent event for hospital staff and community midwives to meet and build relationships and rapport outside of transfer situations
- Publicize existing continuing education opportunities to both community midwives and hospital providers and staff
    - For example, hospitals can do outreach to community midwives about NRP renewal classes and community midwives can do outreach to hospitals about midwife continuing education offerings
- Provide joint continuing education opportunities for hospital providers and community midwives
    - Include simulation working as a team in transfer situations
- Present at grand rounds on community midwife transfers and scope of practice
- Jointly provide training for EMS on community birth transfers

Community Midwife Focused

- Improve prenatal preparation for hospital transfers
    - Provide information at multiple points during prenatal care
    - Provide info on both maternal and newborn transfers
    - Provide information about what to expect during emergent and non-emergent transfer
    - Use transfer planning worksheet to get clients to
    - Encourage clients to pack a hospital bag
    - Encourage preregistration at hospital
- Adopt use of Homebirth Summit transfer forms (See Appendix A)
- Practice communication with hospital prior to arrival

Hospital Staff Focused

- Provide training for staff (using community birth transfer survey results) on:
    - Welcoming community birth transfers (see Tips for Welcoming Community Birth Transfer in Appendix B)
    - Including community midwives in care after a transfer
    - Community midwife training and scope of practice
- Coordinate discharge and postpartum care with community midwife
- Review and improve informed choice for exams, procedures and decisions
    - Provide informed choice training for nurses and providers – We recommend interdisciplinary training in informed choice
    - Review and update written policies

Hospital System Focused

- Create written policy on welcoming community birth transfers
- Provide midwife to midwife transfer where applicable
- Coordinate discharge and postpartum care with community midwife including sending discharge summary for mom and baby
- Create plan for direct admission of community birth transfers to L&D, including postpartum transfers, rather than routing through ED
- Look at postpartum care policies and practices to increase opportunity for uninterrupted rest for new parents
- Change policies/practices to end separation of birthing people and babies
- Create policy (and possible training) for community midwife inclusion in cesarean section of community birth transfer patients
- Examine specific recommendations for improving transfers for BIPOC families (see CBTP Focus Group Report in Appendix C)
- Partner with families/consumers to co-design services, systems, or spaces (L&D and NICU)
- Partner with families fully in the care and decision making for their infant, and themselves, in order to maximize their capability and minimize their stress and anxiety, paying attention to the biological, emotional, spiritual and social determinants of health and wellbeing

Education & Simulation to Improve Community Birth Transfers

Education is an essential part of creating smooth, safe, and collaborative transfer experiences for all involved. Joint continuing education, with a focus on simulation of transfers, is a best practice for transfer improvement and a goal of the Oregon Community Birth Transfer Partnership. Hospital-Community Transfer Improvement Committees can include continuing education in their work and these projects are integrated into the transfer committee section of this toolkit. Hospital-Community Transfer Improvement Committees should prioritize these education projects:

- Presentation on community birth transfers and midwifery at hospital grand rounds
- Include simulation of community birth transfer hand-off in a hospital skills day
- Publicize hospital continuing education opportunities to community midwives
- Publicize community midwife continuing education opportunities to hospital staff
- Run joint midwife-hospital simulation drills
- Encourage use of existing continuing education resources

Whenever possible, education about community birth transfers should be co-presented by a hospital provider and a community midwife.

Continuing Education Resources

The following continuing education courses are already available. All three use a consensus Best Practices in Community Birth Transfer curriculum that was created in 2016-2017 by a group of Oregon community midwives, obstetricians, paramedics, nurses, and other providers. OPC members Silke Akerson and Wendy Smith were key participants in creating this curriculum. For more information about the Best Practices in Community Birth Transfer curriculum please contact silkeakerson@gmail.com

Transfer Tools for Midwives, EMS, and Hospital Providers

4-hour online continuing education (CE) course

Course description: Transfers from home births and birth centers to hospitals happen regularly and are an important part of safe care for birthing people and babies. We know that approximately 10-20% of planned community births (homebirth and birth center births) transfer to the hospital when pain medication or labor augmentation is needed, or when complications arise.

Yet midwives, emergency services personnel, nurses, and receiving hospital providers don't receive training on how to work together as a care team. We often find ourselves trying to provide care in stressful emergency situations without the information or skills we need to do so effectively.

We're ready to change that and work together to improve care! This one-of-a-kind course:

- Is a curriculum designed by and for midwives, emergency services personnel, nurses, and receiving hospital providers
- Shares new collaborative methods for improving home birth and birth center to hospital transfers
- Teaches communication skills critical to keep calm and clear during stressful situations
- Includes clinical best practices
- Models scenarios demonstrating these best practices for communication and care
- Teaches creative tools for bridging relationships with other provider types
- Includes everything you need to know about the other providers involved to support optimal care and smooth transfer across all settings of a community birth transfer

This course will help all provider types work together smoothly so we can improve outcomes and the experience of care for mothers and babies.

For a preview of the course and additional information, please visit: https://www.hivece.com/courses/transfer-tools

Oregon EMS and Trauma Webinar Series: Working with Community Midwives for Smooth Hospital Transfers

Course description: A 1-hour CE webinar for the Oregon Health Authority EMS and Trauma program. Uses curriculum co-created by midwives, physicians, and EMS. Originally presented in June, 2018 and available free online:

Instructor: Silke Akerson, CPM, LDM

https://www.youtube.com/watch?v=hVzY2xelTK0&list=PLcujXb4Cbz1GtSxeXwD9iBGeLcCdhPPOu&index=5

OMC Emergency Transport Skills Simulation Workshop for Midwives and EMS

Description: Oregon Midwifery Council, American Medical Response, and Legacy Emanuel providers have coordinated joint community midwife and EMS emergency transport skills simulation workshops. The workshops cover common problems in transport and their solutions, communication skills with 9-1-1 and EMS, and best practices in maternal and neonatal emergency transport. Emergency scenarios include postpartum hemorrhage, newborn resuscitation, shoulder dystocia, and retained placenta. The workshops are primarily hands-on, providing midwife and EMS participants practice in emergency transport scenarios.

Instructors: Silke Akerson CPM, LDM, Melissa Gordon-Magnus CPM, LDM, Tim Case, Paramedic, Wendy Smith, MD

The course instructors are available to run simulation workshops around the state or to provide guidance for others to do so. For more information contact silkeakerson@gmail.com

Future Continuing Education for Transfer Improvement

Some elements of continuing education are included in the process for hospitals to join the CBTP and in the work of the Hospital-Community Transfer Improvement Committees. There are other continuing education projects that would need broader involvement across regions and hospital systems. The Joint Continuing Education & Simulation Committee of the Community Birth Transfer Partnership recommends the following areas of focus for future continuing education work:

- Create a system to provide regular presentations on community birth transfers to student physicians, nurse-midwives, nurses, EMTs, and paramedics
- Create a system to provide education on hospital transfers to student midwives
- Create a system to incorporate community birth transfer education into OB/Gyn residency programs
- Provide in-hospital simulation trainings of community birth transfers for hospital providers and nurses. Include simulation to hand-off in emergency and non-emergency transfers
- Create an annual joint continuing education simulation workshop for community midwife and hospital providers. Ideally this would be in a different part of the state each year to allow more providers to participate.
- Hold regular joint EMS and community midwife transfer simulation workshops with a focus on working collaboratively in emergency transfers
- Create a platform to publicly share annual Oregon community birth data benchmarking with stakeholders

Whenever possible, education about community birth transfers should be co-presented by a hospital provider and a community midwife.

Protected Joint Case Review for Sentinel Events

Proposal for Protected Joint Case Review for Community Births

Protected joint case review for community birth transfer sentinel events or concerning cases is a best practice for transfer improvement and a goal of the Oregon Community Birth Transfer Partnership. This may happen at an institutional, state, or regional level. The creation of a chartered peer review body for the purpose of community birth case review for quality improvement is one strategy for accomplishing this goal. There are two main options for the creation of a peer review body for legally protected community birth joint case review:

- **State or Regional Perinatal Collaborative**. Creation of a peer review body within a state or regional perinatal collaborative such as the Oregon Perinatal Collaborative.
    - To pursue this option in Oregon, the OPC would need to become a legal entity such as a 501(c)(3) or 501(c)(6) and then form a chartered peer review body within OPC
    - An example of this option is the Northern New England Perinatal Quality Improvement Network (NNEPQIN) Confidential Review and Improvement Board (CRIB): https://www.nnepqin.org/initiatives/
- **Patient Safety Organization.** Creation of a national, regional or state community birth Patient Safety Organization (PSO) for the purpose of protected community birth case review
    - Creation of a PSO would be labor and cost intensive
    - A national PSO could provide structure and protection for this process in every state
    - More information on creating a PSO is available through the Agency for Healthcare Research and Quality: https://pso.ahrq.gov/become

The Oregon Community Birth Transfer Partnership will continue to explore these options with national partners and other state perinatal collaboratives. Protected case review may also occur at the institutional level.

Any type of formalized joint case review will require the creation of a **peer review body** with a charter that is bases in the Oregon peer review statute, ORS 041.675.

Initial recommendations for a peer review body charter:

- Language should be formal
- The charter purpose should mirror the language in ORS 041.675
- Each case review meeting should be planned in advance
- A confidentiality agreement should be shared in advance of each meeting and signed by each participant
- Charter language should recognize the community midwife and the hospital staff involved in a case as members of the care team for that patient

Best Practice Guidelines:
Transfer from Planned Home Birth to Hospital

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

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

The purpose of these guidelines is twofold:

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

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

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

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

Model practices for the midwife

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

Model practices for the hospital provider and staff

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

Quality improvement and policy development

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

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

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

Home Birth Summit, Collaboration Task Force

- Diane Holzer, LM, CPM, PA-C, Fairfax California (Chair)
- Jill Breen, CPM, CLC, Midwife, St. Albans Maine
- Kate T. Finn, MS, CM, CPM, Licensed Midwife, Ithaca New York
- Timothy J. Fisher, MD, MS, FACOG, Chair Department of Surgical Services, Cheshire Medical Center/Dartmouth-Hitchcock Keene, Keene New Hampshire
- Lawrence Leeman, MD, MPH, Professor, Family and Community Medicine, Obstetrics and Gynecology, University of New Mexico, Albuquerque New Mexico
- Audrey Levine, LM, CPM, Licensed Midwife, Olympia Washington
- Ali Lewis, MD, FACOG, OB/GYN, Seattle Washington
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- Tami J. Michele, DO, FACOOG, OB/GYN, Fremont Michigan
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- Saraswathi Vedam, RM, MSN, FACNM Sci D(hc), Professor, Division of Midwifery, University of British Columbia, Vancouver British Columbia

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HBS COLLABORATION TASK FORCE- MATERNAL TRANSFER FORM

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

_____

_____

Status at Time of Transport: ☐ Stable ☐ Unstable

FHTs:	Ctx Pattern:		**Mode of Transport:** ☐ Private Vehicle ☐ EMS ☐ Other EMS Staff:_____ Called:_____Arrived_____ Departed:_____
Dilation/Station:	BP: /		
Last food/fluid PO (date/time):	Temp:	Pulse:	
Last Void Time: _____:_____	Ultrasound Findings:		Time at hospital door: _____ : _____ Time at L&D room: _____ : _____ Time Hospital Provider Received _____ : ____ Time verbal report: _____ : _____
IV Gauge:			
Total infused prior to transport:			

Labor History:

Latent Onset: (date/time): _____ / _____:_____

Active Onset: (date/time): _____ / _____:_____

2nd Stage Onset: (date/time): _____ / _____:_____

AROM/SROM: (date/time): _____ / _____:_____

Birth: (date/time): _____ / _____:_____

Placenta: (date/time): _____ / _____:_____

EBL: _____

Fluid: ☐ CLEAR ☐ MECONIUM ☐ BLOODY

Lacerations: NO YES, Details_____

BACKGROUND

Current Pregnancy Complications: _____

_____

Significant Medical History: _____

_____

Prior Pregnancy Outcomes: _____

☐ NKDA, Allergies: _____ Height / Weight: _____ / _____

Current Medications/Supplements: _____

Blood Type: _____ BP Baseline: _____ / _____ GDM Testing: ☐ YES ☐ NO Hct: _____ (date: _____)

ALERTS: ☐ Rh- ☐ HSV+ ☐ Rubella Non-Immune ☐ HEP B+ ☐ HIV+

☐ GBS Unknown ☐ GBS+ ☐ GBS- (date: _____)

ASSESSMENT: _____

_____

RECOMMENDATION: _____

_____

HBS COLLABORATION TASK FORCE- NEWBORN TRANSFER FORM

Patient's Full Name: _____ ☐ Male ☐ Female Date/ Time: _____ / _____ : _____

Mother's Full Name: _____ Phone # (____) ____ _____ EDD: _____

Referring Provider: _____ Phone # (____) ____ _____ Gestation: _____

Referred to: _____

Does receiving hospital have maternal/ prenatal records? ☐ YES ☐ NO ☐ UNKNOWN

Medical records included: ☐ # Pages: _____

SITUATION and Reason for Transport

_____

_____

Status at Time of Transport: ☐ Stable ☐ Unstable

Mode of Transport: ☐ Private Vehicle ☐ EMS

EMS Staff:_____

Called:_____ Arrived_____ Departed:_____

Time arrival at hospital: _____ : _____

Time Hospital Provider Received _____ : ____

Time verbal report: _____ : _____

Labor History:

Latent Onset: (date/time): _____ / _____:_____

Active Onset: (date/time): _____ / _____:_____

2nd Stage Onset: (date/time): _____ / _____:_____

AROM/ SROM: (date/time): _____ / _____:_____

Birth: (date/time): _____ / _____:_____

Placenta: (date/time): _____ / _____:_____

EBL: _____

Fluid: ☐ CLEAR ☐ MECONIUM ☐ BLOODY

Complications: NO YES, Details_____

NEWBORN TRANSITION: ☐ RESUS ☐ SUCTION ☐ O2 ☐ PPV ☐ CHEST COMPRESSIONS

NEWBORN EXAM: Birth Weight: _____ APGAR: 1MIN: _____ 5 MIN: _____ 10 MIN: _____

Significant Findings: _____

_____

Last VS: Time: _____ Heart Rate: _____ Resp. Rate: _____ Temp: _____ SpO2: _____

Feeding Concerns: _____ Blood Glucose: _____ Last Feed (time): ____ : ____

☐ Eye Tx ☐ Vitamin K (☐ IM / ☐ Oral) ☐ CCHD Screening ☐ Metabolic Screening

MATERNAL BACKGROUND

Current Pregnancy Complications: _____

_____

Significant Medical History: _____

_____

Prior Pregnancy Outcomes: _____

☐ NKDA, Allergies: _____ Height / Weight: _____ / _____

Current Medications /Supplements: _____

Blood Type: _____ BP Baseline: _____ / _____ GDM Testing: ☐ YES ☐ NO Hct: _____ (date: _____)

ALERTS: ☐ Rh- ☐ HSV+ ☐ Rubella Non-Immune ☐ HEP B+ ☐ HIV+

☐ GBS Unknown ☐ GBS+ ☐ GBS- (date: _____)

ASSESSMENT: _____

_____

RECOMMENDATION: _____

_____

Appendix B: Community Birth Transfer Partnership (CBTP) Materials

- Why join the Oregon CBTP?
- Tips for Welcoming Transfers
- Initial Meeting Sample Agenda
- Annual Audit Form
- Sample Community Midwife Transfer Plan
- Sample Hospital Transfer Worksheet

Why Join the Oregon Community Birth Transfer Partnership?

The Community Birth Transfer Partnership (CBTP) is a program of the Oregon Perinatal Collaborative and the Oregon Midwifery Council that supports hospitals and community midwives in efforts to improve planned home birth and birth center to hospital transfers. Perinatal transfers of birthing people who planned a community birth (out-of-hospital birth) can be sources of stress and conflict for hospital staff, families, and community midwives. It doesn't have to be this way.

The Community Birth Transfer Partnership works to enhance the transfer experience for all through safe, collaborative care.

The CBTP can help your hospital:

- ✓ Improve outcomes for mothers and babies
- ✓ Increase patient satisfaction
- ✓ Provide support to staff during a potentially stressful transfer of care
- ✓ Improve working relationships with providers in your community
- ✓ Further a culture of safety and data-driven quality improvement

There is room for improvement. Many families who transferred to an Oregon hospital from a community birth reported concerning experiences of disrespect, lack of informed choice, and even mistreatment or abuse during their hospital stay (OPC Community Birth Transfer Survey Report, 2021).

Collaborative transfer improvement works! Oregon hospitals that have worked on community birth transfer improvement report major positive changes in both relationships and outcomes. The CBTP can provide a quality improvement bundle and facilitation to help hospital providers, nurses, administrators, and community midwives work together to improve communication, relationships and systems of care so that transfers are straightforward, seamless and safe for everyone involved.

We need YOU to make it work! If you are a nurse, provider, or administrator in an Oregon L&D or NICU unit and would like more information or want to join the Community Birth Transfer Partnership, please contact opc@ohsu.edu.

Tips for Welcoming Community Birth Transfers

- Welcome the patient and their support people warmly

- Treat the patient and their support people with respect

- Acknowledge the fear or disappointment they may be feeling about the change in care plan and environment. You can say something like:
    - "I know this is not what you planned. Is there anything we can do to help you in this transition to the hospital?"

    -OR-

    - "I'm happy to care for you. I'm sorry that you're here. I know how hard you worked to have a home birth (or birth center birth)."

- Keep mother and baby together whenever possible

- Treat community midwives with an attitude of mutual respect. You and the community midwife(s) are a care team.
    - It puts patients at ease to see their providers collaborating respectfully

- Provide slow and thorough informed consent about procedures or interventions
    - Remember to provide informed consent about things that you may consider routine such as vaginal exams or rupture of membranes.
    - Seek brief but clear informed consent even in an emergency.
    - Informed consent makes a difference in patient experience of care. Community midwifery clients expect it at all times.

- Do not assume that the patient is not ready for interventions upon arrival. In many situations, the community midwife and patient will have already thoroughly discussed a plan for an epidural and Pitocin augmentation or a needed cesarean section.

- Work with the community midwife to communicate with the patient about needed procedures or interventions if there is resistance. Many patients will want to hear the midwife's opinion or advice or talk privately with their support person and midwife before consenting.

- Ask midwives for information and input as needed. Midwives know lots about their patients and what has happened so far.
    - Some receiving providers find including the community midwife in the care when appropriate helps ease the transition and improve the patient experience of care

- Coordinate postpartum care with the community midwife

- If you have concerns about follow-up care after discharge, communicate them directly to the community midwife.

- Ensure that records and discharge summary are sent to the community midwife.

Initial Meeting Sample Agenda

1. **Introductions**
2. **Background information**
   - Hospital information: number of births/transfers per year, newborn care/NICU capacity, provider types
   - Community midwives: number of midwives and birth centers, births per year, types of midwives
   - Past relationship of hospital and community midwives
   - Our intention is for safe care and improved collaboration moving forward
3. **Mission and Goals of Oregon Community Birth Transfer Partnership**
   - *Mission:* To realize a mutually respectful and integrated healthcare system that supports patient/client safety and satisfaction and increases community midwife and hospital collaboration when transfer occurs from community birth to hospital settings.
   - *Goals:*
     - Eliminate barriers to safe and timely transfers from planned community birth settings to in hospital care settings.
     - Increase consumer engagement in advocacy and quality improvement efforts related to safe transfers of care.
     - Promote interprofessional collaboration to encourage productive, collegial relationships grounded in respectful, patient/client-centered care.
     - Expand skills, knowledge, and relationships through meaningful interprofessional case reviews and continuing education.
4. **Oregon Community Birth Transfer Partnership Steps**
   - **Hospital hosts initial Oregon Community Birth Transfer Partnership presentation**
     - An Oregon Community Birth Transfer Partnership representative will talk with hospital staff and community midwives before the presentation to understand the current transfer situation and hospital-community midwife relationships.
   - **Identify hospital and community midwife advocates**
     - Identify a nurse, nurse-midwife or obstetrician who can serve as the advocate for the hospital and a community midwife who can serve as the advocate for the midwifery community. These individuals will coordinate meetings and communication between the groups.
   - **Form a Community Birth Transfer Committee**
     - Assemble a group of obstetricians, nurse-midwives, nursing staff, pediatric providers, EMS personnel, and local community midwives to form the Community Birth Transfer Committee.
   - **Produce and adopt transfer tools**
     - The committee works collaboratively to develop transfer protocols, forms and other tools to support smooth transfers. The Oregon Community Birth Transfer partnership will provide templates.
   - **Regular meetings**
     - Once initial work to adopt transfer tools is completed, the Community Birth Transfer Committee meets 1-2 times each year to assess any concerns or issues and to work together to continually improve community birth transfers.
     - These meetings can also be used for shared continuing education, transfer simulation drills, and protected case reviews as needed.
   - **Data collection**

    - Participating hospitals collect data to evaluate the transfer improvement program. This data can be used for improvement at the hospital level, to improve the OPC (insert name of program here), or for research and publication.

5. **Set up ground rules for the meetings**
    - Establish ground rules from communication in the meetings so that everyone can be heard. Some areas to consider: How will cases be discussed? How can we communicate and give feedback respectfully across differences?
6. **Areas of concern / Areas for improvement**
    - Give time for both hospital and community midwife participants to describe concerns related to community birth to hospital transfers
    - Discuss initial ideas for improvement
7. **Planning for future meetings**
    - Frequency, timing, location
    - Topics/Agenda. Are there standing agenda items that will be discussed at every meeting?
    - Designate hospital and community midwife advocates and make a plan for how communication will work. Share contact info.
    - Create contact list of community midwives to be invited to future meetings.
8. **Closing comments**

Future Meetings

- Be sure to address agenda items identified at the first meeting.
- How are transfers going? Are protocols and other tools working? What needs modification? Use group problem-solving to work with the feedback these questions generate.
- Review hospital and survey data if available
- Identify needs for education, training, or additional transfer tools
- Share meeting minutes with the hospital and community midwives

Community Birth Transfer Partnership Annual Audit Form

You can use this form for self-assessment and in preparation for meetings of the community birth transfer improvement committee.

Hospital Name: _____ Reporting Year:_____

Report Date: _____

Data on Outcomes

1. Total maternal community birth transfers from January 1 to December 31: _____

   Transfers by receiving provider:

   a. OB Hospitalist: _____

   b. Nurse-Midwife: _____

   c. Private practice OB: _____

   d. Family practice doctor: _____
2. Total neonatal community birth transfers from January 1 to December 31: _____
3. Total number of emergency community birth transfers: _____

   a. Maternal _____

   b. Neonatal
4. What were the 3 most common reasons for maternal community birth transfer?

5. What were the 3 most common reasons for neonatal community birth transfer?

6. How many maternal community birth transfers resulted in cesarean section? _____
7. How many maternal community birth transfers resulted in blood transfusion? _____
8. How many community birth transfers resulted in NICU admission for reasons other than observation? _____

Oregon Perinatal Collaborative Community Birth Transfer Partnership

Hospital Experience of Community Birth Transfers

Please describe your assessment of community birth transfers in your hospital over the past year in relation to the following areas of interest. Do not include any HIPPA-protected identifying information.

1. Maternal and newborn health:

2. Smooth and efficient transfer process:

3. Mother/birthing parent and family experience:

4. Community midwife and hospital staff communication:

5. Hospital provider and nursing satisfaction:

Community Birth Transfer Improvement Program Information

1. Does your hospital have:

A maternal transfer protocol?	Yes	No
A neonatal transfer protocol?	Yes	No

2. Was/were your protocol(s) developed by hospital staff and community midwives? Yes No
3. Does your hospital have a community birth transfer improvement committee? Yes No
    a. If yes, how often does the committee meet per year?
4. Does your hospital collect data on community birth transfer? Yes No
    a. If yes, please describe your data collection:
5. Do you review hospital data on community birth transfers at your meetings? Yes No
6. Do your patients who transfer from planned home birth or birth center births complete the CBTP Community Birth Transfer Survey? Yes No
    a. If no, why not?
7. Does your hospital participate in case reviews with community midwives? Yes No
    a. If yes, please describe:
8. Does your hospital participate in joint continuing education or simulation with community midwives? Yes No
    a. If yes, please describe:
9. Has your hospital created resources or tools to support community midwife to hospital transfers? Yes No
    a. If yes, please describe:

10. What are some current challenges to working collaboratively with community midwives?

11. What successes has your hospital experienced in working with community midwives?

12. How can the Oregon Community Birth Transfer Partnership help your hospital improve community birth to hospital transfers?

Report completed by:

Name: _____

Position: _____

Email: _____ Phone: _____

Sample Community Midwife Hospital Transfer Plan

It may become necessary, or you may elect, to transfer to a hospital before, during or after the birth. The decision to transfer to a hospital is made by midwives and/or clients for medical or other reasons.

We usually transfer care to _____ or _____ Hospital. Both hospitals provide supportive care to women who have transferred to the hospital from a planned home birth. We prefer hospitals that have neonatal intensive care units (NICU) and anesthesia available 24 hours.

Non-Emergency Transports

We will transport you and/or the baby by private vehicle in a non-emergency situation. We transport to hospitals where we have established relationships with the Nurse-Midwives and obstetricians and feel confident that our clients will receive respectful and appropriate care. In a non-emergency situation, we are happy to transport you to a hospital that is compatible with your health insurance coverage or preferred by you for any reason. We will call ahead to the hospital to give the accepting provider basic information about your case and let them know when we plan to arrive.

When transporting by a private vehicle, we will have equipment available for an emergency delivery. Midwifery care will continue as appropriate including accompaniment to the hospital. At the hospital we will transfer your care to the hospital staff. To ensure that you have continuity of care at least one of the midwives will stay with you to provide support and serve as a liaison with hospital personnel.

Emergency Transports

In an emergency transport we call 911. EMTs (Emergency Medical Technicians) will provide medical support and transport to the hospital. They will determine which hospital is appropriate and take you there by ambulance. At least one of your midwives will either travel in the ambulance or follow in a private vehicle. We will call ahead to the hospital to alert them to your transfer and give them information about your case and the care you may need upon arrival.

As in a non-emergency transport we will transfer your care to the hospital staff. To ensure that you have continuity of care, at least one of the midwives will stay with you to provide support and serve as a liaison with hospital personnel.

In case of a hospital transport during your care, we plan to go to the following hospital unless that hospital is on divert, EMS chooses another hospital, or there is another reason to change the plan:

Hospital:_____ Phone number _____

I/We have read and understand the above information about hospital transports. I/We understand that we and/or our midwives may decide to transfer our care to the hospital at any time before, during or after the birth for any reason.

Printed name: _____ **Date:** _____

Signature: _____

Sample Hospital Transfer Worksheet

While most births in our practice occur at home, about 1 out of 10 of our clients end up giving birth in the hospital, most commonly because of the need for therapeutic rest or pain relief during a long labor, but sometimes for more urgent reasons such as signs that a baby is not tolerating labor well. More rarely we may transport a mom or baby to the hospital in the first minutes to hours after birth for unresolved bleeding (in mom), breathing problems (in baby) or other concerns.

We don't know ahead of time who will need the additional tools available at the hospital around the time of birth so we ask all of our clients to think about and prepare for this possibility. It can be hard to think about transferring to the hospital when you are planning a home birth but our clients who have needed to go to the hospital have all said that preparation and information ahead of time were very helpful. For these reasons, we ask you to please fill out this worksheet and share it with us during the hospital transfer discussion at your next visit.

Name: _____ **DOB:** _____

In case of transport, my preferred hospital is: _____

If I give birth in the hospital, I want our midwives and hospital providers to remember these preferences, requests, and plans (How would you like to make the space your own? Do you want the routine newborn procedures? How do you feel about noise, light, cord clamping?):

If I give birth by cesarean section these are my requests (Who would you want in the room? Do you want the baby to be placed on your chest immediately? If the baby needs to go to the NICU who will go with the baby?):

If my baby is sick and needs more than routine care in the hospital these are my requests (Would you want to stay with the baby with you as much as possible? Do you have requests related to antibiotics, medications, formula?):

My biggest fears about hospital transport are:

I have the following questions about hospital transport:

Appendix C: Family/Consumer Research and Feedback

- Community Birth Transfer Survey (available online: https://www.surveymonkey.com/r/OPCBirthTransfer)
- Community Birth Transfer Survey Report
- Community Birth Transfer Focus Group Guide
- Community Birth Transfer Focus Group Report

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

Thank you for sharing about your experience of a home birth or birth center to hospital transfer. Your feedback helps us improve the transfer process for birthing families across Oregon.

The Oregon Perinatal Collaborative advocates for improved maternal and neonatal outcomes through collaboration, implementation of evidence-based practice, and policy change throughout the state of Oregon. This survey is part of our efforts to improve the safety and experience of community birth to hospital transfers.

The survey will take about 10-20 minutes to complete. Your responses are voluntary and will be confidential. There are opportunities at the end of the survey to share any additional comments you would like. We do not collect identifying information such as name, date of birth, or medical record number. All responses will be grouped together and analyzed as a group.

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

About You

These questions give us a better sense of who is experiencing community birth transfers so that we can tailor our work to meet your needs.

* 1. How old are you?

- ◯ 15-19
- ◯ 20-24
- ◯ 25-29
- ◯ 30-34
- ◯ 35-39
- ◯ 40-44

2. How do you describe your race/ethnicity? Check all that apply

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino or Chicano
- ☐ Indigenous
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or European

* 3. Are you insured by OHP (Medicaid)?

- ◯ Yes
- ◯ No

* 4. Do you identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual (LGBTQIA)?

- ◯ Yes
- ◯ No

* 5. Do you have a disability?

- ◯ Yes
- ◯ No

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

About Your Transfer Experience

These questions help us understand what families experience during community birth transfers so that we can make changes to improve.

* 6. What was the year of your hospital transfer?

* 7. What was the location (city/town) of the receiving hospital?

8. What is the name of the receiving hospital? You do not have to provide the name of the hospital if you do not wish to for any reason.

* 9. Did your midwife discuss the possibility of transfer with you?

- ◯ Yes
- ◯ No

* 10. Did you feel prepared for the possibility of transfer prenatally?

- ◯ Yes
- ◯ No
- ◯ I'd like to describe my experience below:

* 11. Before your transfer, how likely did you think it was that you or your baby would need to transfer to the hospital during labor, birth, or postpartum?

- ◯ Very unlikely
- ◯ Unlikely
- ◯ Undecided
- ◯ Likely
- ◯ Very likely

* 12. Why were you and/or your baby transferred to the hospital?

* 13. Did you and/or your baby transfer to the hospital by private car or ambulance?

- ◯ Private car
- ◯ Ambulance

* 14. Did you transfer in labor?

- ◯ Yes
- ◯ No

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

Transfer in labor

* 15. How long did you labor at home/birth center?

- ◯ 0-2 hours
- ◯ 3-5 hours
- ◯ 6-12 hours
- ◯ 13-24 hours
- ◯ More than 24 hours

* 16. How long did you labor in the hospital?

- ◯ 0-2 hours
- ◯ 3-5 hours
- ◯ 6-12 hours
- ◯ 13-24 hours
- ◯ More than 24 hours

* 17. If you transferred during labor, were you initially care for by an obstetrician or a nurse-midwife?

- ◯ Obstetrician (doctor)
- ◯ Nurse midwife
- ◯ I don't know

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

About Your Transfer Experience, Continued.

* 18. What type(s) of providers did you and/or your baby receive care from after your transfer? Check all that apply.

- [ ] Obstetrician
- [ ] Nurse Midwife
- [ ] Maternal-Fetal Medicine
- [ ] Nurse
- [ ] Pediatrician
- [ ] Neonatologist
- [ ] Social Worker
- [ ] I don't know

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

About Your Transfer Experience, Continued.

During and after your transfer were you given clear information about the risks, benefits, and alternate options related to your care?

* 19. By your home birth or birth center midwives?

- Yes
- No

* 20. By the receiving hospital doctor or midwife?

- Yes
- No

* 21. By the receiving hospital nurse?

- Yes
- No

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

About Your Transfer Experience, Continued.

During and after your transfer did you feel that your desires/choices were respected?

* 22. By your home birth or birth center midwives?

- Yes
- No

* 23. By the receiving hospital doctor or midwife?

- Yes
- No

* 24. By the receiving hospital nurse?

- Yes
- No

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

About Your Transfer Experience, Continued

* 25. Did you experience any of the following types of mistreatment during or after your transfer? Select all that apply.

- [ ] Shouting, scolding and/or verbal abuse
- [ ] Threats, intimidation, and/or coercion about accepting treatment(s) you did not want
- [ ] Refusal of requests for help and/or threats to withhold treatment
- [ ] Violation of your privacy
- [ ] Touch, examinations, or procedures without your consent
- [ ] None of the above

* 26. Do you think you experienced poor treatment based on your appearance, identity, race or another factor?

- ( ) Yes
- ( ) No
- ( ) Yes, and I'd like to describe my experience:

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

About Your Transfer Experience, Continued

* 27. Please select all procedures and outcomes that you experienced.

- [ ] Intravenous Fluids (I.V.)
- [ ] Labor induction
- [ ] Pitocin to increase strength and/or frequency of contractions
- [ ] Epidural
- [ ] IV antibiotics (for mother)
- [ ] Infection (mother)
- [ ] Vacuum extraction
- [ ] Forceps
- [ ] Episiotomy
- [ ] Cesarean Section
- [ ] Postpartum Hemorrhage (mother bled too much after birth)
- [ ] Resuscitation of baby
- [ ] Infection (baby)
- [ ] IV antibiotics (for baby)
- [ ] Baby admitted to NICU
- [ ] Death of baby

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

Your Transfer Experience, Continued

* 28. Were you offered follow-up with your home birth or birth center midwives after you left the hospital?

- ◯ Yes
- ◯ No

* 29. How would you describe the interactions and communication between your community midwife and the hospital staff? Select all that apply.

- ☐ Friendly
- ☐ Collaborative
- ☐ Mixed interactions
- ☐ No direct communications
- ☐ Respectful
- ☐ Disrespectful
- ☐ Tolerant
- ☐ Hostile
- ☐ Other (please specify)

30. What went well in your transfer experience?

31. What could have been better in your transfer experience?

32. What else would you like us to know about your transfer experience and the care you received?

33. What else do you want us to know about this survey or our work to improve community birth to hospital transfers?

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

Focus group participation

34. Would you like to participate in a focus group to help us improve the transfer process for birthing families across Oregon? Each focus group will meet for 1-2 hours online to talk about your experiences and let us know what midwives and hospitals could do better.

- ◯ Yes
- ◯ No

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

Focus group participation

35. You indicated you are interested in participating in a focus group. Please enter your email address below so we may contact you. Your email address will **only** be used for focus group purposes and will not be linked to your survey responses. Please proceed to the next page to submit the survey after entering your email address.

Oregon Perinatal Collaborative

Oregon Perinatal Collaborative: Client Community Birth Transfer Survey

Thank you!

Thank you for completing the survey. Please click 'submit' below when you are ready to submit your responses.

Taking a survey about your birth experience may have brought up challenging feelings and you may need support. These are two resources for dealing with difficult birth experiences or emotional challenges after birth:

Baby Blues Connection
1-800-557-8375
http://www.babybluesconnection.org/

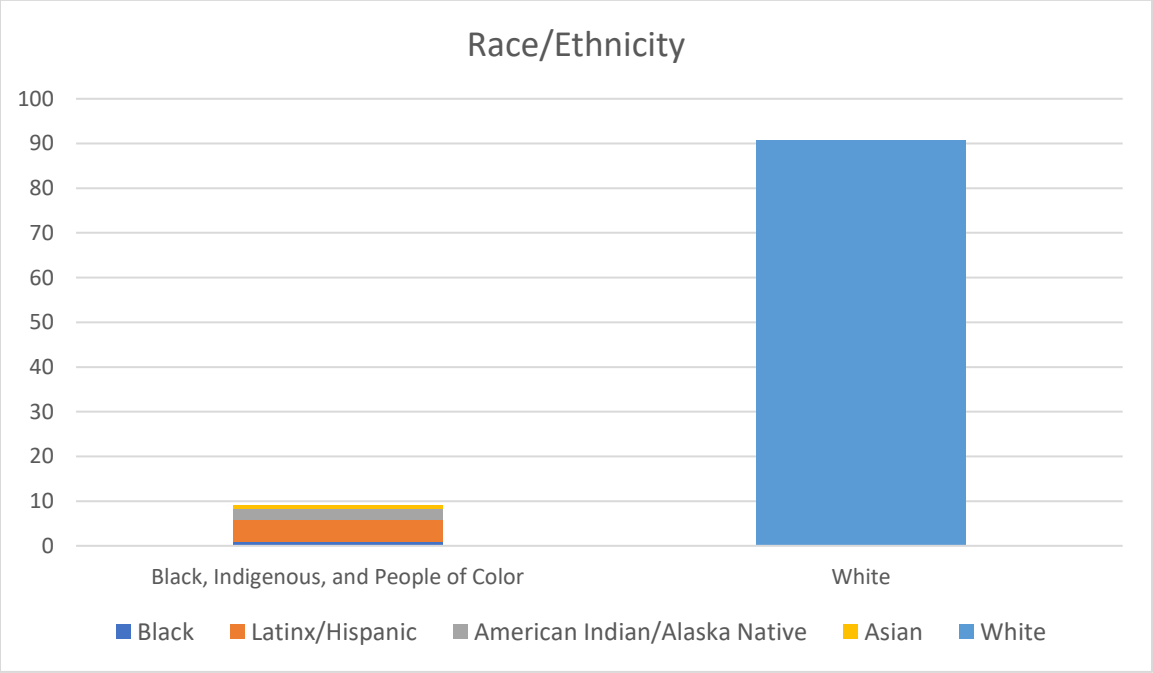
Postpartum Support International
1-800-944-4773
https://www.postpartum.net/

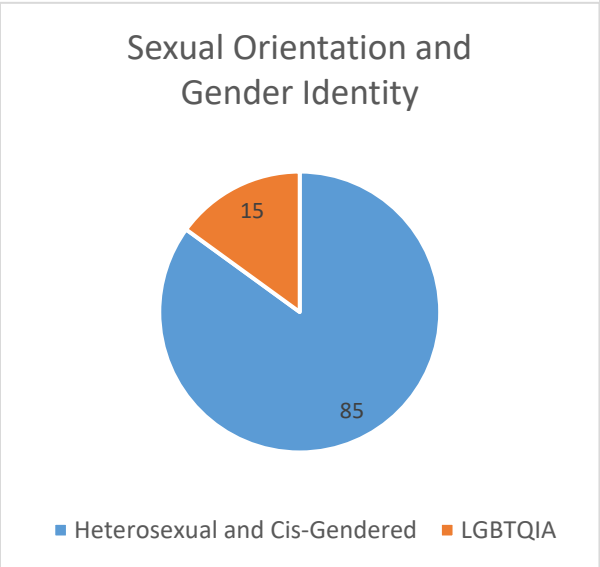
Oregon Community Birth Transfer Partnership

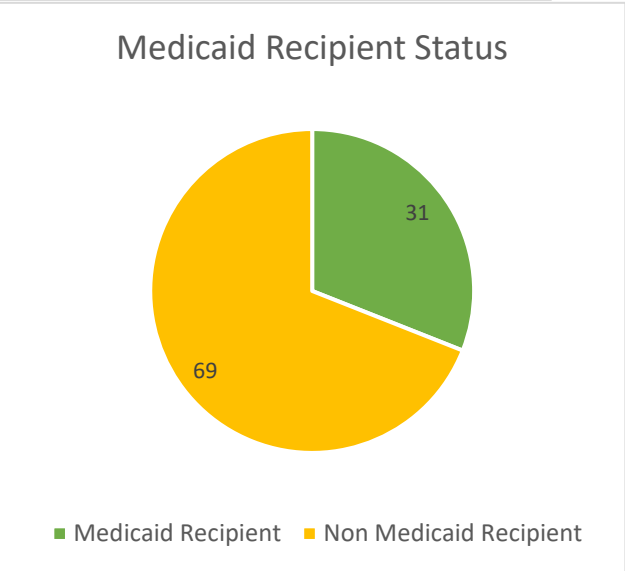
Community Birth Transfer Survey Report

In November, 2020 the Oregon Community Birth Transfer Partnership (CBTP), a joint program of the Oregon Perinatal Collaborative and the Oregon Midwifery Council, launched a survey to collect information from birthing parents who experienced a transfer from a planned home birth or birth center birth in Oregon. The survey asked about their transfer experiences and their feedback for quality improvement of community birth transfers. We received 119 survey responses in the first 4 weeks[i]. This report is a summary of those responses for use in the program development phase of the CBTP.

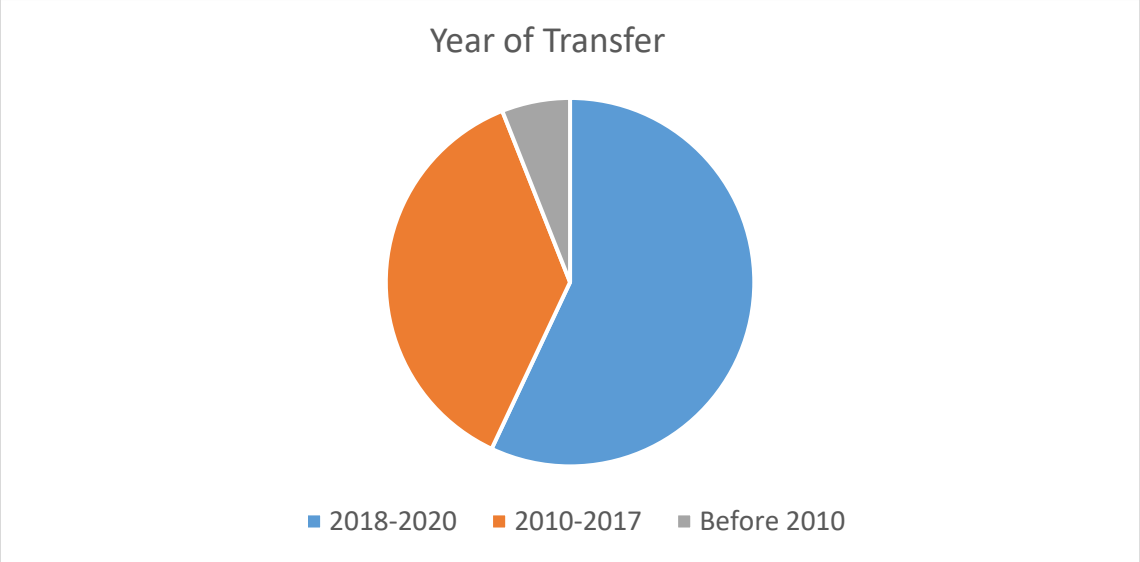
Respondent Demographics







Time and Location of Transfers



There was broad geographic representation including the following hospitals:

Portland Metro Area
OHSU
Legacy Emanuel
Providence Portland
Providence St. Vincent
Adventist
Kaiser Sunnyside
Tuality

Central + Eastern
St. Charles
Grande Ronde

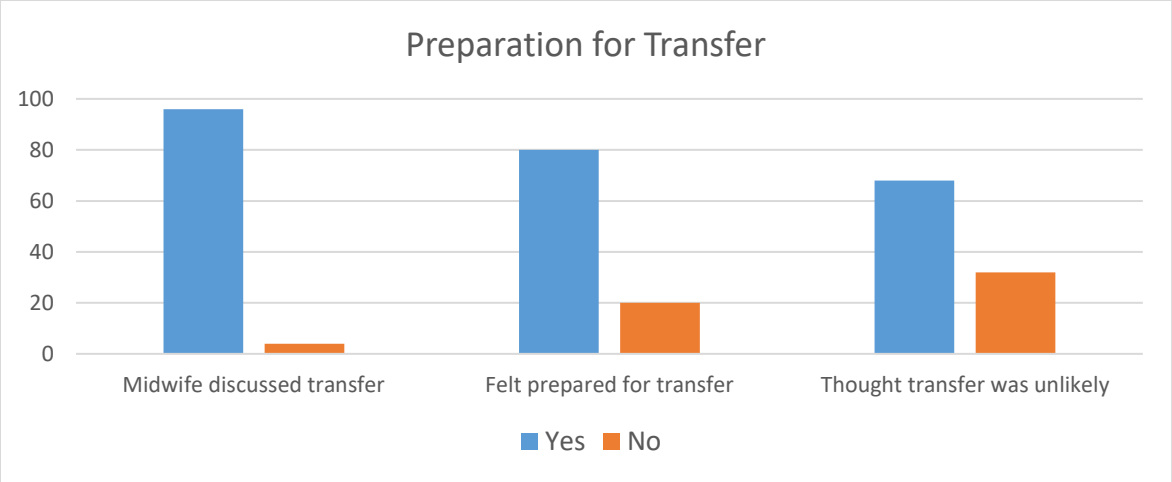
Mid-valley
Salem Hospital
Albany General
Legacy Silverton
Good Samaritan Corvallis
Good Samaritan Lebanon
Santiam Hospital

Coast
Peace Health Florence

Southern
Asante Rogue Regional
Asante Ashland
Asante Three Rivers
Providence Medford

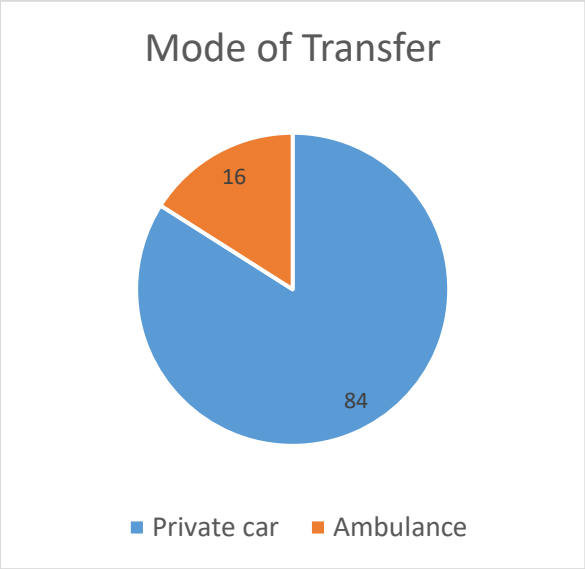
Eugene Area
Peace Health Riverbend
McKenzie Willamette

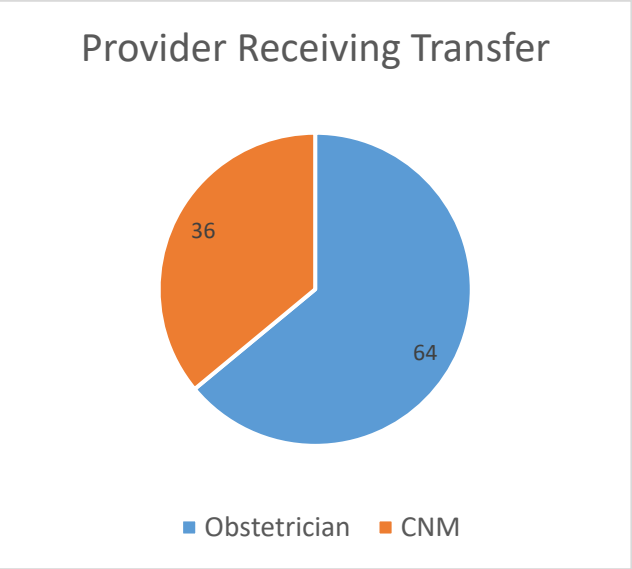
Preparation for Transfer



Despite nearly universal midwife discussion of hospital transfer, a full 68% of respondents thought it was unlikely or very unlikely that they would need to transfer.

Transfer Data



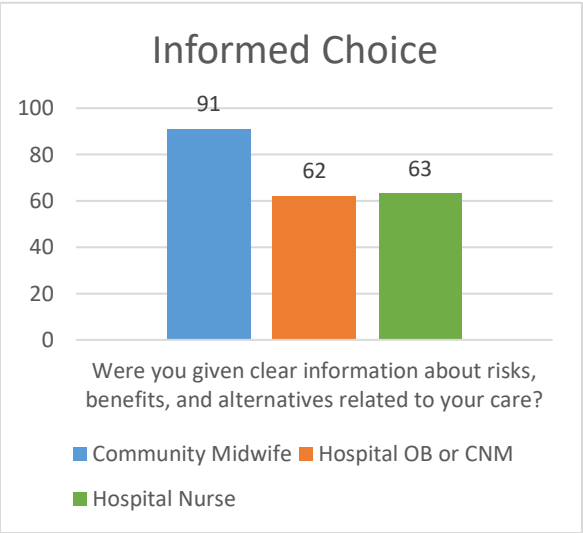


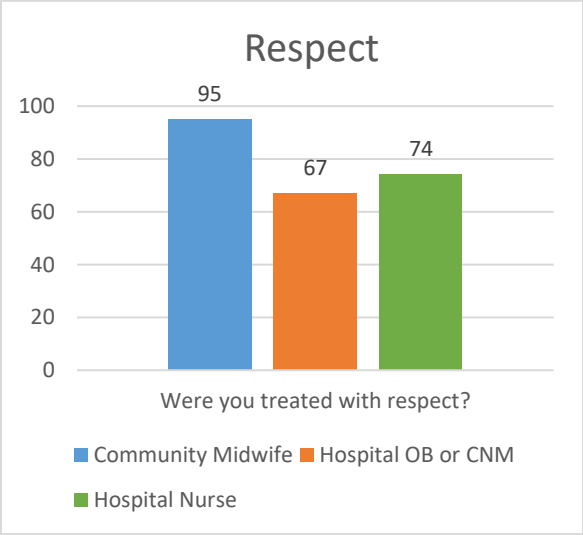
Long labor or failure to progress was the most common reason for transfer (almost 40% of the transfers). The next most common reasons for maternal transfer (in descending order) were: Abnormal FHT, prolonged rupture of membranes, postpartum hemorrhage, breech presentation, blood pressure, and pain management.

Newborn transfers were less common (9% of responses) and were primarily due to respiratory distress (ranging from mild symptoms to prolonged resuscitation)

Informed Choice and Respect

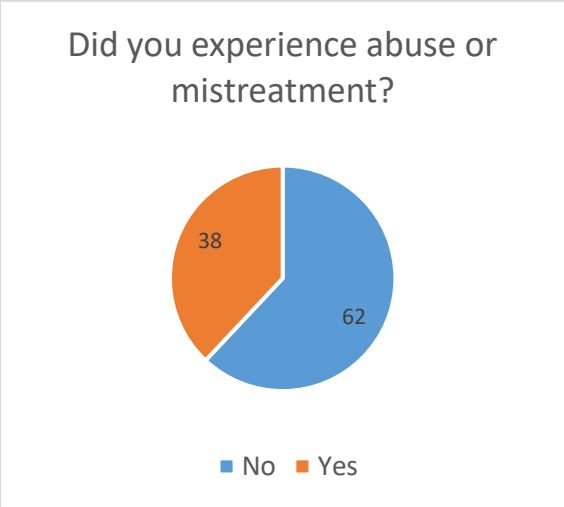
Respondents reported significant differences between provider types when asked if they were given informed choice and treated with respect by community midwives and hospital staff.

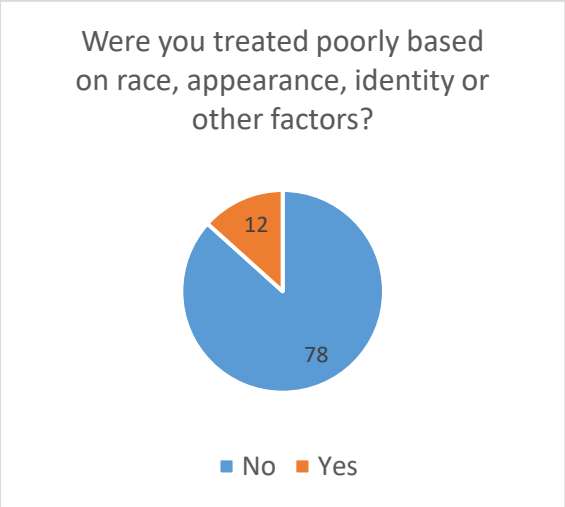




Mistreatment and Abuse

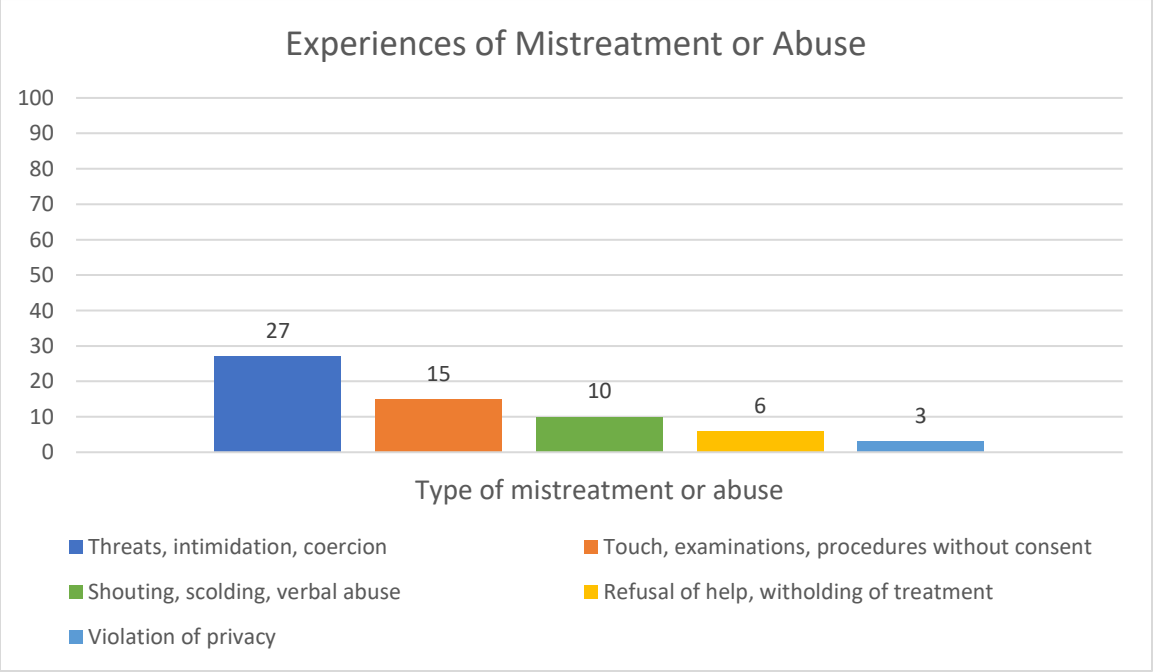
Many respondents reported experiences of mistreatment or abuse during a transfer. Threats, intimidation, and/or coercion were the most commonly reported forms of abuse.





Most of those respondents who believed that they were treated poorly based on their appearance, identity, race or another factor perceived the poor treatment was due to being a community birth transfer while a small number felt it was based on perceived poverty or body size.

"They wanted to tie my tubes and it felt like it was because I was a single mother and poor. The[y] also expressed frustration and insinuated it was irresponsible that I had tried a home birth."



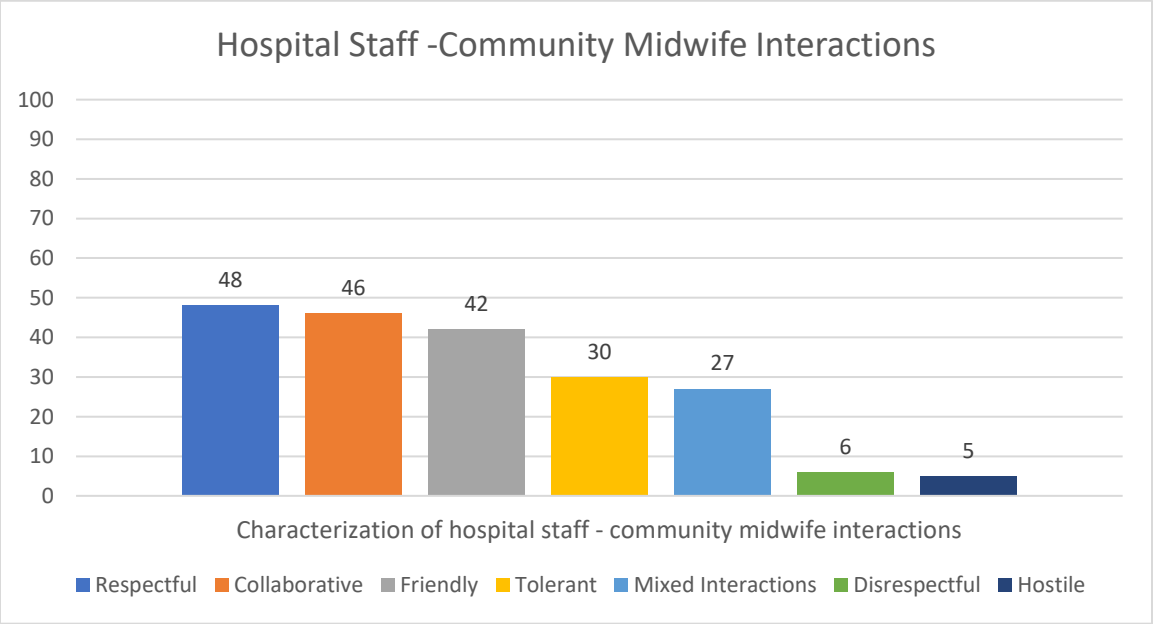
Outcomes

We collected birth outcomes data in a manner that was challenging to analyze. I recommend revising this section of the survey with an eye to how we want to use the data for future use. I will highlight just a few key outcomes here:

- 39% of respondents had a cesarean section. 16% of respondents had a baby in the NICU for treatment or observation. There was 1 intrauterine fetal demise.
- 99% of respondents were offered follow-up postpartum care with the community midwife. This is the standard of care.

Hospital Staff and Community Midwife Interactions

Respondents were asked to describe the interactions they observed between community midwives and hospital staff. They reported a wide variety of interactions.



Mother/Birthing Parent Experiences

The qualitative data was a rich source of information about family/consumer experiences of community birth transfer and hospital care. There were a number of frequently occurring themes in the responses including respect, informed choice, and the importance of the community midwife as a support person during transfer. As a convenience sample, there is selection bias that may lead to oversampling of negative community birth transfer experiences in this survey. This does not mean that the trends in the results are not accurate, simply that there may be some overrepresentation of negative experiences. The sample size was large enough I will present the themes here, along with representative quotes from the survey, starting with the most frequent themes.

Community Midwife as Support, Comfort, and Advocate

By far the strongest theme in the survey responses was that mothers/birthing parents wanted their community midwife with them and experienced her presence as supportive, comforting, and protective. Respondents relied on their community midwife for a sense of security in a challenging situation and some described their community midwife as an interpreter between the two worlds/cultures/approaches. Respondents were particularly positive in their description of their transfer experience when they felt like their midwife was included in collaborative care. A number of respondents described how helpful it was that their community midwife was able to stay with them during a cesarean section.

"…the presence of my CPM was absolutely crucial to a smooth transition."

"I would not have felt safe or in control without my midwife there. Period."

"My midwife stayed with me through the transfer and was allowed to scrub in for the cesarean. This brought me so much peace!"

"I had wonderful continuity of care, as my homebirth midwife remained my care provider at the hospital. I felt respected and supported by all of the providers we saw, and I was allowed to go at my own pace without feeling rushed or pressured into any interventions or decisions I wasn't ready for. I believe having my midwife stay with me contributed to this experience."

One respondent was unable to have her midwife accompany her due to COVID-19 and the impact on her experience was significant:

"The difference in care was very difficult for me. I had been with my midwife my whole pregnancy then after transferring I lost my support. I felt out of my comfort zone, exhausted and confused as to why my baby wasn't coming down…The doctor was rude and made me feel awful and like a failure. Cervical checks were terrible and disheartening…. the difference in care was a harsh reality. I missed out on my natural homebirth and ended up with a c section and a loss of self."

Respect

Respect was the second most common theme in the responses. General respect and respect for their autonomy and choices specifically was extremely important to the respondents. Those mothers/birthing parents who felt respected felt positive about their experience. Those mothers who felt they were not respected often described anger, disappointment, and trauma related to their experiences.

"The OB was super respectful toward myself and my midwife team and it made all the difference in the world."

"Multiple staff invalidated my experience. They did not communicate clearly or kindly with me overall. They were slow to respond to my infant's breathing issues. They did not care about me the way the midwife did. The difference in quality of care was such a stark contrast."

"There is no continuity of care or respect for women/parents at the hospital, especially after you give birth. It was like being held in a prison or being held hostage."

"I have high health literacy because I am a perinatal mental health provider… and I am a researcher studying perinatal healthcare. I understand the limitations of hospital protocols in labor and delivery, so it was very easy for me to assert myself and decline continuous BP monitoring, for example. I also easily expressed boundaries about protocol interventions for my baby and me postpartum that I assessed were unnecessary at the time. However, my positionality is not reflective of most, and it is very clear how difficult it is for birthing people to self-advocate within the systems of hospital-based labor and delivery and during such a vulnerable time. In fact, avoiding this rigid and disempowering system of control was precisely why I elected to attempt a homebirth, and while I don't feel badly about my hospital delivery and my transfer was smooth…, I do wish I didn't have to work so hard to have my personal needs and interests respected within the hospital setting."

Informed Choice

Another common theme that emerged was informed choice. Lack of informed choice was one of the main issues that respondents had with their hospital care. Respondents compared the level of informed choice in the hospital with what they were accustomed to in midwifery care unfavorably. When respondents felt like they had received informed choice it was a large part of what they described as positive about their experience.

"It felt like informed consent did not exist. With my midwife, we had a thoroughly discussed plan for everything, including things like IV antibiotics, infant eye drops, vitamin k, etc. at the hospital no questions were asked and even after my son was born via c section, if his dad had not been with him, our son would have gotten the eye drops which we had planned to not receive. (He stopped her right as she held the bottle over my son's eyes)."

"I would have like to know all the risks associated with the possible drugs and inducing methods. When I asked nurses at the hospital they basically said there was no risk, and had to go look up drug side affects for me as they couldn't answer my questions."

"We felt very patronized the entire stay. Informed consent was not given."

"my husband had to argue with her about waiting to cut the umbilical cord and she reached inside me and pulled out my placenta without my consent"

"I was absolutely not given informed choice about my induction-I found out afterwards I could have been allowed to wait rather than rush to induce. No one told me or my wife we could wait, and the consequences of that were emotionally and physically devastating."

"When I was unsure I wanted a blood transfusion they gave me plenty of time to think it over, and gave me true informed consent."

Positive Experiences

Many respondents had positive transfer experiences. Common themes in these experiences were that mothers/birthing parents felt that they were treated with respect and kindness, not rushed, and given informed choice. Respondents definitely noticed when hospitals made an effort to be welcoming to transfers. The word "respect" was used in most of the comments about positive hospital experiences.

"The hospital was respectful to me and really listened and did their best to consider and accommodate my needs."

"We were all treated respectfully, and the nurses in particular understood a hospital induction was not at all what I wanted."

"I had an excellent transfer experience. I was treated with respect throughout the entire process."

"The admitting nurse was great and friendly and the hospital midwife was very informative. It was also very nice that they assigned me a doula who took pictures during her delivery."

"Honestly the whole experience was way more pleasant than I anticipated. The nurse who cared for me before and after my c section shared that she had birthed all of her kids at home. I felt like there was no judgment from any of the staff members, and that they were truly acting in our best interest. It seemed like they tried everything they could to preserve a vaginal birth, and they were empathetic when deciding to move to a c section. They also called my midwives to discuss their rationale."

Preparation for Transfer

Another theme in the responses was preparation for transfer. Only a few respondents felt fully prepared for transfer and a number of them expressed that they avoided thinking about transfer because of their strong belief in natural birth.

"I felt prepared in the sense that I trusted my midwife 100% and felt confident in that I would be okay and she knew when and how to make that call, but mentally I was not. But I know a large piece of that was me not wanting to 'put it out in the universe' because of a core belief I hold about birth not having to be a medical event."

"I knew it was a possibility but I was not mentally prepared and did not have a bag packed. I considered it an unlikely occurrence."

"I intentionally didn't dive too deep into looking into hospital transfers... I left at the end of my birthing classes when they started talking about c sections and I was so certain I would have a home birth."

"Our midwife fully prepared us for the possibility of transfer, kept us calm, and set clear expectations throughout the entire process."

Bias Against Community Birth

Many respondents perceived bias from hospital staff against community birth, especially home birth. This ranged from mild to severe and included reports of being mocked or shamed for attempting a home birth.

"We were judged treated unkindly as irresponsible people who endangered our baby through home birth. They resented us asking questions about treatment."

"Upon arrival (brand new father and his newborn) the admitting person insulted my husband saying something about how she hoped he was at least responsible enough to have insurance."

"I was treated poorly by two different nurses when they learned I had just had a home birth. One nurse implying that had I not had a home birth I wouldn't have had a hemorrhage."

"It felt awful to be treated as less than because of my home birth. Instead of being treated with care and support by nurses, it felt they were looking down their nose at me because I still ended up at the hospital."

"There is a lot of work to be done to improve how moms are treated when they need to transfer. They receive even more of the abuse they so desperately wanted to avoid in the hospital when they need to transfer. Most moms who choose out of hospital birth are doing so because they don't want to be coerced and abused by doctors and nurses. To feel like their birth "failed" and to be met with aggression by the care providers who they are forced to interact with, just adds to the mental health problems that are so prevalent in the postpartum period."

Major Positive Impact of a Welcoming Provider

Another common theme was that having even just one welcoming provider or nurse made a huge positive impact on the person's experience of transfer. Some respondents directly stated that individual providers or nurses prevented the experience from being traumatic or harmful.

"There was one RN on the second day of the hospital stay who actually treated us kindly, respected our choices, and helped protect our rights as parents. Between her and the delivering OB, they changed my overall experience in the hospital and I feel prevented what could have been a difficult and traumatic experience."

"One of the OBs and the pediatricians were nice and respectful. The OB who told me she had to take me for an emergency c section was kind, I could tell she knew she was telling me the last thing I wanted to hear. There was a nurse midwife who was extremely kind. Although even with her, I would often feel forgotten about in the crazy hospital system."

"The OB I first met with upon arrival was pushy and felt like eager to deliver at the end of her shift. My body and baby decided to wait for the next doctor and we are so glad, he was quiet, calm, respectful and encouraging as I brought my baby earthside."

Mistreatment

Respondents shared a significant number of experiences of mistreatment in the hospital. Vaginal exams were a common focus of these stories of mistreatment.

"The nurses would try scare tactics to get me to do what they wanted. Also, I was "checked" by about 10 hands and I found that to be too much"

"Obstetric violence occurred during a vaginal exam."

"The hospital treated myself my midwife, my friends and family like absolute garbage."

"She gave me an episiotomy at the last second without my consent"

"Neonatologist was threatening and unwilling to hear concerns."

"During a contraction at surgery prep, I sat up for more comfortable position and a nurse (gently) pushed me back down telling me not to move. That's not caring for a patient, that's running me through a system."

"During pushing the obgyn gave an open ended threat in the way of saying "if you don't push baby out in the next push.....", which was not an appropriate way for expressing urgency or knowledge of the step that would need to be taken next"

"The doctor was quite rough when she was examining me. Extremely painful, and the baby's heart beat went eratic while she was doing it. She seemed displeased that I was there. She seemed rushed about the decision to do a c-section as she was going off shift shortly."

Collaboration

Respondents expressed gratitude and positive feelings when they noted collaboration between hospital staff and community midwives. It was a topic that was highly associated with positive feelings about the transfer. Alternately, respondents who perceived that the community midwife was disrespected expressed disappointment and frustration.

"Amazing! The obstetrician really respected my midwife's knowledge and let her be actively involved in helping me labor. They collaborated and explained things together for me. I was so impressed, pleased and grateful."

"My midwife was very respectful. But I did not like how the staff treated her, they looked down upon her. And were also very uneducated on what a midwife was capable of."

"My home birth midwives provided all the pertinent information to the hospital nurse midwives timely. I felt like they really worked together to make the transition work as well as possible. Additionally, even though I didn't receive direct medical care from my home birth midwives once under the care of the nurse midwives, they were present during my birth and I felt like I still had that continuation of care."

"The nurse midwives at the hospital were amazing. They let me push in many different positions and were such cheerleaders. Also, my home birth midwives were in the room the whole time and that really helped. Especially when we had decisions to make that we hadn't thought out yet, it was great to get information from them."

"I believe that if a transfer is looked at as a collaboration and not fault on any parties involved would be best. Undermining the chosen care provider for an individual is not an appropriate reaction on incoming individuals in such a high stress situation. The person who was chosen was chosen based on factors that include a trust that is not a

part of the hospital environment, so instilling collaboration and respect will help ease any additional stress on the mother and father."

Control

Respondents expressed a desire to be in control. When respondents described being in control it was always in the context of a positive transfer.

"The hospital was very accommodating to our wishes, and I felt like my husband and I were in full control of our birth decisions."

Separation of Mother and Baby

Separation of mother and baby, even briefly, was a strong concern of respondents.

"It was very difficult for me and my partner for me to be separated from my baby during that short time."

"Once we were in the hospital, we were beholden to their rules. This included separation while our baby was treated in the NICU, which has had long-lasting negative effects. Even with a fairly positive transfer experience, we dealt with certain hospital staff acting as sort of gatekeepers to me accessing our baby, and that's just not ok."

"I shouldn't have been separated from my baby for most of her first 48 hours. She was sent to [another hospital] and they wouldn't let me come with her, they made me stay at [hospital] for blood transfusion and gave me no option to leave to follow her"

"baby [should stay] with mom 100%, Not wheeled to a deserted corner to "recover" entirely alone for 30min."

Respondent Recommendations for Improving Community Birth Transfers

Mothers/birthing parents had clear recommendations for improving community birth transfers both at the provider and system levels. The following is a summary of their recommendations for each provider group, as well as for hospital systems and community midwife and hospital collaboration.

Community Midwives

- Work on relationship with hospitals
- Discuss transfer earlier and more in depth
- Encourage clients to pack a bag for transfer
- Communicate clearly with the hospital before arrival
- Give clients space to process transfer experience
- Provide resources like videos, books, or support groups for processing trauma and grief

EMS

- Provide training on community birth transfers for EMS
  - Laboring people want calm and respectful care
- Let baby and mother ride in ambulance together regardless of who is the patient

- Communicate clearly with hospital before arrival

Hospital Staff

- Act with kindness and respect
- Improve informed choice in all examinations, procedures and decisions
- Don't rush
- Support birthing person to be in whatever position she wants
- Welcome and include the community midwife
- Do not express judgement about the parent's choice of community birth or other choices
- Work on communication and warmth
- Coordinate discharge and postpartum care with community midwife
- Understand and communicate that a transfer is not a "failed" home birth or birth center birth but is appropriate care

Hospital Systems

- Provide midwife to midwife transfer
- Coordinate discharge and postpartum care with community midwife
- Do not route community birth transfers through the ED.
    - This is especially a concern in the postpartum period
- Do not separate mothers and babies. Create flow of care even in urgent situations around keeping mother and baby together
- Support skin to skin immediately at birth including in cesarean sections
- Allow community midwives in OR during cesarean sections
- Create a more peaceful and comfortable environment physically and socially/emotionally
- Ensure all providers and staff are communicating the same policies to families
- Improve maternal postpartum care after discharge for all patients (respondents said they would not have had sufficient care without follow-up community midwife care)
- Reduce postpartum interruptions when mother/birthing parent is resting
- Structure labor rooms & policies to encourage full freedom of movement for laboring person
- Train hospital staff on welcoming community birth transfers
- Provide vaginal breech birth options
- Provide more lactation support
- Provide and promote option of prenatal preregistration and hospital tour for people planning community birth
- Provide rapid access to epidural if transfer is specifically for pain relief
- Allow non-admitted newborn to stay with admitted mom
- Provide clear information about the cost of services

NICU

- Remove any policy or practice impediments to parent access to their baby in NICU
- No gatekeeping of parent access to baby
- Provide mental health support to parents with baby in NICU

- Refrain from expressing judgement (verbally or nonverbally) about parent choices

Collaborative

- Continue projects like the current OPC collaborative project
- Build relationships and work on communication outside of transfers

The mothers/birthing parents who responded to this survey were very happy to be asked what they think. They thanked us for doing this transfer improvement work and encouraged us to continue.

Report compiled by Silke Akerson.

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[i] 10 responses were incomplete so results for each question were calculated using the total number of responses for each particular question.

Oregon Perinatal Collaborative Community Birth Transfer Partnership

Community Birth Transfer Focus Group Guide

Facilitator Instructions

Your role is to guide each of these groups of mothers/birthing parents in a discussion of their experiences of home birth or birth center to hospital transfer with a focus on drawing out suggestions for changes that hospitals and healthcare providers can make to improve the transfer process. We are interested in input to help us improve any aspect of the experience of care.

Please review and become familiar with this guide and each of the focus group questions before the focus group. Participants will be familiar with the intent of the group and will already have signed consent forms for participation. We are planning for 4-6 participants in each focus group.

Focus Group Outline

Initial Information

Orient participants to the group and focus group:

- We expect this group to last about 90 minutes but have scheduled 2 hours in case it goes longer
- Please take breaks as you need
- Feel free to breastfeed or interact with your baby and children as needed
- Please mute yourself if it gets noisy where you are
- Please enter a favorite plant name instead of your name into your zoom profile so that your name doesn't appear in the recording of the focus group.
- The meeting will be recorded and several researchers will watch the recording and potentially use a transcription of the recording to write a report with your feedback for the Oregon Perinatal Collaborative to use in creating a community birth to hospital transfer improvement program. No names or identifying information will be included in the report to the Oregon Perinatal Collaborative.
- Do we have your permission to begin recording?
    - If there are any "no" responses: ask if there are questions/concerns that need resolved before recording begins. If not easily resolvable, continue focus group without non-consenting person(s).

Ground Rules

1. Please participate. Hearing from each person will help us learn the most to improve home birth and birth center to hospital transfer for families in Oregon.

2. Please take turns. Some people like to talk more than others but we want to hear from everyone so we ask you to pause and let another person speak first if you've already had a chance to respond to the current question. Also, if more than one person is speaking at once it is hard to transcribe what you're saying.

3. It's okay to disagree but please be kind and respectful to each other. It is useful for us to hear different experiences and opinions.

4. Please do not share the any of the stories you hear in this group with anyone.

5. Are there any additional ground rules that you would like us to use?

Confidentiality: Anything you say here today will be confidential. Your names or other identifying information will not be included in the report to the Oregon Perinatal Collaborative. We are interested in what you have to say, not in who says what. We want you all to feel like you can speak freely.

We will be asking a series of questions about your home birth or birth center to hospital transfer. When we say "transfer" that is what we are referring to. We are hoping to learn how to improve the transfer process by hearing from you about your experiences.

Maternal focus group interview questions

1. Can you talk about how prepared you felt for the possibility of a hospital transfer before you went into labor?
    a. How did your midwife(s) prepare you for the possibility of a hospital transfer?

2. What was the reason for your transfer to the hospital?

3. What about your transfer experience went well?

4. What didn't go well in your transfer experience?
    a. How could that have gone better?

5. What would you like to see change in home birth and birth center midwife practices around hospital transfers?

6. What would you like to see change in how hospitals receive and care for home birth and birth center transfers?

7. Respect was a strong theme in the survey responses. What does respect mean to you? What would indicate to you that a doctor, nurse, or midwife was treating you with respect?

8. What would the ideal home birth or birth center to hospital transfer look like?
    a. What recommendations would you make for your midwifery team to improve the transfer process?
    b. What recommendations would you make to the hospital to improve the transfer process?

9. What else do you think we need to know to ensure that Oregon families who transfer to the hospital from a home birth or birth center birth receive respectful and safe care?

Thank you so much for participating in this focus group. A report on these focus groups will be made available to you by May 1, 2021. Your experience and input are essential to our efforts to improve home birth and birth center to hospital transfers. Talking about your birth and hospital transfer experiences may bring up challenging feelings and it is normal that you may want to talk about what this group has brought up for you. We encourage you to reach out to a friend or other support person if you need to talk further. Please remember that the stories of other people in this group are private and not to be shared. If you need more support please contact Baby Blues Connection or Postpartum Support International.

Baby Blues Connection

1-800-557-8375

http://www.babybluesconnection.org/

Postpartum Support International

1-800-944-4773

https://www.postpartum.net/

Neonatal Intensive Care Unit (NICU) focus group questions

1. Can you talk about how prepared you felt for the possibility of a hospital transfer before you went into labor?
    a. How did your midwife(s) prepare you for the possibility of a hospital transfer?
    b. How did your midwife(s) talk about newborn transfers or what to expect from newborn care in the hospital before your birth?

2. What was the reason your baby was admitted to the NICU?

3. What about your transfer experience went well?
    a. What went well in the NICU experience?

4. What didn't go well in your transfer?
    a. What did not go well in the NICU experience?
    b. How could that have gone better?

5. What would you like to see change in home birth and birth center midwife practices around hospital transfers?

6. What would you like to see change in how hospitals receive and care for home birth and birth center transfers?

7. What would you like to see change in hospital NICU practices?

8. Respect was a strong theme in the survey responses. What does respect mean to you? What would indicate to you that a doctor, nurse, or midwife was treating you with respect?

9. What would the ideal home birth or birth center to hospital transfer look like?
    a. What recommendations would you make for your midwifery team to improve the transfer process?
    b. What recommendations would you make to the hospital to improve the transfer process?

10. What else do you think we need to know to ensure that Oregon families who transfer to the hospital from a home birth or birth center birth receive respectful and safe care?

Thank you so much for participating in this focus group. A report on these focus groups will be made available to you by May 1, 2021. Your experience and input are essential to our efforts to improve home birth and birth center to hospital transfers. Talking about your birth, hospital transfer, and NICU experiences may bring up challenging feelings and it is normal that you may want to talk about what this group has brought up for you. We encourage you to reach out to a friend or other support person if you need to talk further. Please remember that the stories of other people in this group are private and not to be shared. If you need more support please contact Baby Blues Connection or Postpartum Support International.

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BIPOC focus group questions

1. Can you talk about how prepared you felt for the possibility of a hospital transfer before you went into labor?
    a. How did your midwife(s) prepare you for the possibility of a hospital transfer?

2. What was the reason for your transfer to the hospital?

3. What about your transfer experience went well?

4. What didn't go well in your transfer experience?
    a. How could that have gone better?

5. What would you like to see change in home birth and birth center midwife practices around hospital transfers?

6. What would you like to see change in how hospitals receive and care for home birth and birth center transfers?
    a. What would you like to see change to improve safety and experience of care for families who identify as Black, Indigenous or people of color?

7. What barriers do families, who identify as Black, Indigenous, or people of color, may face during a home birth or birth center to hospital transfer?
    a. Any fears?
    b. Concerns?

8. Can you describe differences, if any, you experienced in your treatment than other people?
    a. In the context of race and ethnicity.

9. Respect was a strong theme in the survey responses. What does respect mean to you? What would indicate to you that a doctor, nurse, or midwife was treating you with respect?

10. What would the ideal home birth or birth center to hospital transfer look like?
    a. What recommendations would you make for your midwifery team to improve the transfer process?
    b. What recommendations would you make to the hospital to improve the transfer process?

11. What else do you think we need to know to ensure that Oregon families who transfer to the hospital from a home birth or birth center birth receive respectful and safe care?

Thank you so much for participating in this focus group. A report on these focus groups will be made available to you by May 1, 2021. Your experience and input are essential to our efforts to improve home birth and birth center to hospital transfers. Talking about your birth and hospital transfer experiences may bring up challenging feelings and it is normal that you may want to talk about what this group has brought up for you. We encourage you to reach out to a friend or other support person if you need to talk further. Please remember that the stories of other people in this group are private and not to be shared. If you need more support please contact Baby Blues Connection or Postpartum Support International.

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Community Birth Transfer Partnership Focus Group Report

In February, 2021 the Oregon Community Birth Transfer Partnership (CBTP), a joint program of the Oregon Perinatal Collaborative and the Oregon Midwifery Council, conducted focus groups to collect information from birthing parents who experienced a transfer from a planned home birth or birth center birth in Oregon. Participants were asked about their transfer experiences and their feedback for quality improvement of community birth transfers. 14 birthing parents participated in 4 focus groups: one for birthing parents who are Black, Indigenous, and People of Color, one for maternal transfers in the Portland Metro area, one for maternal transfers in other parts of the state, and one for parents whose babies had been in the neonatal intensive care unit. This report is a summary of their responses for use in the program development phase of the CBTP.

It was important to us to hear from birthing parents who are Black, Indigenous, and People of Color (BIPOC) about their experiences and recommendations for improving community birth transfers. BIPOC birthing parents have expert advice to offer us on how to respond to the crisis in maternal and infant health caused by racism. The input of BIPOC birthing parents can help us reduce harm and improve outcomes and the experience of care for birthing families. We have highlighted the input of BIPOC participants throughout this report and have included a section on their specific recommendations to improve care for BIPOC families.

Birthing Parent Experiences and Feedback

Birthing parents shared illuminating information about their birth experiences and the ways that community birth to hospital transfers could be improved. The following are the core themes that emerged from all four focus groups.

Respect

Respect was a key theme in the focus groups. Since respect had been such a consistent value for survey respondents, we asked focus group participants to describe what respect meant to them and how they would know they were being respected during birth and postpartum. Participants wanted providers to ask them about their preferences and plans, provide complete informed choice, and respect their decisions without attempts at coercion. They wanted providers to remember that they work for birthing people, who are in charge of making decisions about their bodies and their babies. They wanted providers and nurses to listen to them, welcome questions and welcome it when they advocated for themselves. The wanted to be included as full partners in their care. They also wanted verbal consent for all procedures including routine things like taking a blood pressure. To the focus group participants, respect means:

“Giving me the information and then trusting me enough to know that I can make a decision for myself based on that information without fear mongering… All of us want to be safe ourselves, and we want our babies to be safe, and if you lay out the information and present all the information to us, I think you should respect us enough to know that we will make the right choice based on that information.”

“Not only just listen to what I value but also work to implement those things for me… Look at it as a partnership.”

“Being truly listened to… my preferences and values being taken into account… my voice being the authority, the ultimate authority in the birth situation.”

“Treat someone else how you want to be treated… like I am a human being, you are a human being, I am capable of making decisions, you are capable of making decisions…. We might have completely different beliefs and we might have completely different value systems and like that's fine and that's something that… Yes, I may believe something different, but that doesn't mean that my belief is wrong and that doesn't mean that I am any less than anybody else.”

“I want looped in the conversation when it comes to my own care and the care of my child.”

Reasons for Choosing Community Birth

Focus group participants often described their reasons for choosing a home birth and expressed their desire for hospital providers and nurses to understand these motivations. This was especially important to participants in the BIPOC focus group who wanted hospital providers and nurses to understand that avoiding institutional racism and a desire to observe cultural traditions were part of their decision-making. One Black participant expressed that she was afraid to give birth in the hospital because of the experiences of Black moms who have not been listened to or believed about their concerns in hospital care. Another participant in the BIPOC focus group shared what she wanted hospitals to understand about these choices,

"I think that the medical community, hospitals and clinics specifically need to have an awareness that some people's preference for more like natural or low-intervention birth is cultural and not just like some hippie new age movement. That it's actually a return to roots and actually very important on like a spiritual level for people."

Several focus group participants shared that they chose home birth specifically because of safety so it was jarring to feel judged by the hospital as though they had made a choice that was unsafe or endangering. Participants shared that they researched their options and made educated choices to have a community birth. They were frustrated to find that some hospital staff perceived community birth as an uneducated choice. Participants also talked about choosing community birth as a way to have autonomy and control during birth.

"I chose a home birth because I've seen what happens in the hospital and I wanted the autonomy to say what was happening in my birth and to know that no means no and that every procedure, everything would be ran through me first."

"Home birth is a way for women to take back a strength that they have"

Contrasting Experiences of Care in Home and Hospital

Focus group participants frequently contrasted their experiences of community midwifery care and hospital care in ways that may be illuminating for providers and nurses seeking to understand the differences in these models of care. They described feeling like active and central participants in their care with community midwives but being pushed to a secondary or lesser position when they transferred to the hospital. One participant articulated that she felt like she had to be accommodating to the staff, rules, policies, once she entered the hospital.

"At home, I was very much a part of every decision that we made. I am capable of being a member of a decision-making team like it's my life, it's my child's life. And, it felt like at the hospital, instead of being treated like the mother of my child, I was also being treated like a child."

"I feel like I'm a chart and not a person and so they're looking at the numbers first and not me as an individual versus, be like, I see you're a person, also these numbers are here. Like numbers don't tell a whole story and never will and so like why aren't you asking questions about like my experience and what I'm looking for?"

Participants also described feeling celebrated and surrounded by encouragement while they labored at home and lamented the loss of a sense of celebration and magic in the hospital setting.

"It was so exciting, it was like I'm bringing life into the world, and then I get to the hospital and it's just like let's hook her up to the two machines and let's watch these numbers and everything just felt like it was taking away the magic."

Good Care

Focus group participants had clear ideas of what constitutes good care. Much of their conception of good care centered around slowing down, listening, and offering kindness. They emphasized that birth and hospital transfer experiences affected them for months and years and providers need to understand how large their impact can be. They liked it when

providers took the time to listen, provide explanation, and give space and time to process major decisions. BIPOC participants emphasized that each birthing person is unique and birth is not a production line. The following are elements of good care that focus group participants described:

- Slow down and listen
- Recognize us as whole people
- Talk us through what is about to happen
- Offer kindness and gentleness
    - Small kindnesses like a NICU nurse supporting skin-to-skin after initial mother-baby separation and a CNM bringing a picture of a baby to a mom recovering from a cesarean before she could see him made a big difference
- Don't share information or talk about decisions during contractions
- Partner with the birthing person as an active member of the care team
- Offer empathy about wanting a home birth and about the challenges of a hospital transfer
- Check in and answer questions after and emergency or surgery

Participants appreciated seeing the hospital staff and community midwife work collaboratively together. Those who had midwife-to-midwife transfer were pleased with the option.

"I literally wouldn't have changed anything about how my midwife handled it before, during or after I think it was fantastic, and I think the relationship they had with the hospital is amazing."

When participants did not feel that they had received good care, it was often related to not being listened to and not having their questions answered.

"During the C section I was shaking and scared and I don't feel like anyone really addressed like my questions asking of like, is this normal that I'm shaking? when will it stop?"

There was a fairly stark difference between participants perception of intrapartum and postpartum care. Many focus group participants said that they had good labor and birth experiences but bad postpartum experiences due to interruptions, judgement, and lack of support.

Community Midwife as Support, Comfort, and Advocate

Continuity of care with their community midwife was important to all the focus group participants but especially the BIPOC participants. Participants described a trust relationship with their midwives that they relied on in an unfamiliar or distressing situation. They described their midwife as a translator, explaining things in language they understood. When their community midwife had relationships with the hospital, they felt like it eased the experience of transfer. Participants were upset when the community midwife was treated poorly or seen as a "visitor" rather than a member of the care team. Several participants experienced the community midwife as a buffer or protector when a hospital provider was being aggressive or threatening.

"It was really nice have my midwife there because it was somebody I trusted and had seen throughout the duration of my care. When they were asking… can we put you know, like a heart rate, monitor and baby's head… I didn't look at them to ask the questions, I looked at my midwives like, Is this something that's okay? …. So, it was really nice to know like, somebody that I trusted and felt was very competent was there, and you could just see the relationship between my midwives and their midwives was very strong."

Participants appreciated it when their midwife could be with them throughout each step of the transfer process including being with them in the ambulance and in the operating room. A number of participants described how useful it

was for them that their community midwife walked them through what would happen during the transfer, or what was happening during a procedure, step-by-step.

“My midwife got to stay with me through the entire delivery…She was reassuring me, letting me know what was going on…She talked me through everything that was happening.”

Informed Choice

Focus group participants wanted to see the model of informed choice that they experienced in midwifery care adopted in the hospital. They wanted clear informed choice with full information on risks, benefits, and alternatives. They wanted time to consider their options and respect for their decisions without continued attempts to persuade them if they chose something other than what was recommended. They described the need for informed choice even in emergency situations. Participants wanted to remind providers that birthing people are focused on the safety of their babies and should be trusted to make decisions. They wanted providers to know that lack of consent causes trauma. They recognized that something can be painful or hard but not traumatizing when the birthing person is a consenting and active partner.

“What I loved about my midwives, is that they said, you know here are the options, these are the pros, these are the cons… you make the decision.”

“With my midwives, they were also, like the best example of consent I've ever had where they're like about to do something they're like Okay, let me tell you what's going to happen, you can stop at any point. I don't know that anything happened that was terrible in that sense in the hospital, but I felt the absence of the conversation. Of like, let me explain what's going to happen. When that's missing… you're just left to fill in the blanks.”

“I have the choice, and I have the ability to decide what's best for my body, and for my baby.”

Preparation for Transfer

Most of the participants felt mentally prepared for transfer but not emotionally prepared. Many reported that, though their midwife described transfer, they did not think it would happen to them. Some described themselves as being in denial about the possibility of transfer. Participants in the Portland metro area reported more midwife preparation for hospital transfer than those in other parts of the state. Those participants who did feel prepared for hospital transfer described more detailed planning conversations with their community midwife.

[Transfer]was definitely talked about as… a very real possibility. I'm a first-time mom too so it's definitely something my midwives went over like at our first visit and we had… our hospital bag all packed. Everything was prepared for that possibility. But I think in my head, I still kind of felt like it wouldn't happen.”

“My midwives prepared me that it was a possibility and also gave some pretty clear guidelines of when… we had reached the safety level for their practice and their care, but I personally was in denial that it would ever happen to me. And so, I mentally was not prepared for that move. I did not have a hospital bag packed. I'm actually a CNM so I thought I knew it all and that I knew what to expect, and I was wrong.”

“*[The midwives] talked about common reasons people are transferred… Yeah, I mean just in every appointment checking in like what might be indicators that we might need to transfer. They gave us a form that I think was more for us [with] what things are important in the birthing process, whether it's home birth or hospital birth that we really want as part of our experience. So I mean that was really helpful… especially since like once we got to the hospital… she was able to keep some of those things in mind.”*

Focus group participants offered advice for community midwives to improve transfer preparation. There was an emphasis on the importance of repeated conversations and offering information in multiple formats. Their specific recommendations for improving transfer preparation are included later in this report.

Bias and Mistreatment

Black, Indigenous and People of Color focus group participants reported more experiences of mistreatment or abuse within the hospital than white participants. An Indigenous participant described being threatened with a call to Child Protective Services if she did not comply with a treatment plan. She felt that she was viewed as difficult and combative when she tried to advocate for herself. When she reflected on the experience of other Indigenous mothers she knows or supported during birth, she said that they were treated well if they were compliant and passive and treated poorly if they advocated for themselves or expressed that they didn't like something. A Black participant described a provider stating that she was too high risk for VBAC because of being Black. BIPOC participants described these experiences as contributing to their perception that the hospital was not a welcoming place for people of their race/ethnicity.

The most frequent forms of mistreatment reported by focus group participants were threats and verbal abuse. Participants described feeling demeaned and angry when they were threatened by obstetricians or pediatricians when they did not consent to testing or treatment. Multiple participants reported threats that insurance would not cover their care if they did not consent to a recommended plan. They wanted providers and nurses to understand that many people already have had experiences of medical mistreatment before they give birth and these behaviors bring up those experiences and undermine the care relationship.

"The nurse in Labor and delivery kind of was not so nicely yelling at me to not push in the hallway when I couldn't particularly control it"

"The OB… gave me a veiled warning like, if you don't push him out this next time and, like left this big hanging thing. I really didn't appreciate that."

A number of participants reported that hospital providers or nurses were dismissive and made assumptions because they had planned a home birth. They wanted hospital staff to understand that they planned to give birth at home for a reason and that they were transferring for a reason and needed understanding not judgement. Participants also described bias from providers during when they accessed screening or additional care prenatally. These experiences exacerbated distrust of the hospital.

"I had my 20 week ultrasound [and] the ultrasound tech and the doctor were like, you should transfer your care to [hospital]. It's just this type of thing, like well why are you trying to pressure me into doing that?"

Separation of Mother and Baby

Participants reported that any separation from their baby was extremely painful. Participants used strong language in describing these separations with one person saying that she felt "crazy with the need" see her baby. They expressed heartbreak and grief at the loss of the golden hour and did not accept that the separation was necessary. They wanted hospitals to understand that practices and facilities should be structured around keeping mothers and babies together. One participant wanted providers to know that even a few minutes with her baby before he was taken to the NICU would have made a big difference. One person said that the presence of her community midwife in the recovery room before she could see her baby was helpful. Another expressed that she wanted to see more understanding in the hospital of the mental health impacts of mother-baby separation.

"After I had my C section, when I wanted to see my son, yes I'm super grateful that he's healthy and he's breathing. But I also can do nothing to fight this absolutely intensive biological urge to hop out of this bed while my body is still numb and run and find wherever the NICU is and get to him."

Neonatal Intensive Care Unit

Concerns about respect, autonomy, and informed choice were accentuated for those participants who had babies in the Neonatal Intensive Care Unit (NICU). They reported that it was challenging to impossible to have their plans and preferences for newborn care honored by hospital staff. They wanted recognition from providers and nurses about the trauma of having a baby in the NICU. Participants wanted NICU providers and nurses to collaborate with them as members of the baby's care team. The NICU experience was especially challenging for those participants whose babies were in NICUs that did not have rooming in. Some participants described feeling like they had to fight to be discharged because the providers viewed them as unsafe because they planned a home birth.

"The majority of the time I'd get there and they'd already be feeding her formula… but I had already pumped stuff to give to her, and I was there to breastfeed her and it just didn't matter."

"We weren't allowed to fall asleep in the chair sitting in the NICU so I mean it was after 48 hours of labor and no sleep, I then had to, if I wanted to see my daughter and be near her, I had to stay awake in the NICU."

Postpartum Care

Many focus group participants reported that they had good experiences during labor and birth but not during postpartum care. There was agreement among participants that hospitals need to improve their postpartum care, both in the hospital and following discharge. They especially thought that follow-up care after cesarean section and hospital communication with the community midwife about follow up care should be improved.

"The transfer was amazing. The birth was amazing. It was afterwards, where it was just like we felt like we had to fight for everything."

"At one point my partner actually like stood outside the room and wouldn't let anybody come in, because it was just so disruptive and I couldn't sleep and if we had to do this again, I think he would do that more or we would have been more empowered to say like please, we don't want anyone for the next four hours or something because I really don't think coming in every two hours is necessary medically."

"The most shocking to me was how much attention I was getting up until like my baby left my body, and then there was, like the only follow care by my health care provider was a six-month video appointment and so that was it. Like I had a C section and there's like zero follow up and I had to like fight for pelvic floor therapy."

Recommendations for Community Birth Transfer Improvement

Focus group participants were asked for their recommendations on how community midwives and hospitals could improve the community birth transfer process. The following is a summary of their recommendations divided into specific areas for improvement.

Recommendations to improve experiences and outcomes for BIPOC families

- Listen to women. Listen to mothers
- Recognize that birth is physical, emotional, and spiritual
- Recognize that birthing people need their support people and accommodate them
- Provide care and support in the birthing person's primary language
- Work towards the goal of collaborative co-care between community midwives and hospital providers

- Provide public education about birth options, midwives, and community birth
    - Especially in BIPOC communities and rural areas
    - Include information on changing care providers if it is not a good fit
- Welcome the community midwife into the hospital.
    - The birthing person wants her there and may experience her as protective in a system that she wanted to avoid
- Provide training for hospital providers on cultural awareness and mortality/morbidity experienced by Black moms and babies
- Mandate universal insurance coverage of midwives and doulas
- Increase OHP payment for doulas

Recommendations for Community Midwives

- Community midwives should increase and improve preparation for hospital transfers
    - Encourage preregistration at the hospital
    - Encourage packing a hospital bag
    - Create an individual written transfer plan with documentation of preferences and choices for care (such as newborn procedures)
    - Provide education about what to expect in the hospital
    - Use handouts for hospital transfer education
- Ask for feedback from clients who transfer and adjust practices based on feedback

Recommendations for Hospital Staff

- Treat the birthing person like a partner in their care
- Welcome and include the community midwife
- Respect parent choices about newborn care
- Don't judge birth choices or parenting choices
- Acknowledge that the transfer is a major transition and this isn't where she wanted to be
- Validate the birthing person's experience
- Ask the birthing person why she wanted a home birth and how she is feeling about the transition to the hospital
- Don't talk down to birthing people verbally or physically (get down to their level)
- Take more time to explain procedures and why they need to do something
- Remove the stigma around planning a home birth
- Don't rush. Slow down.
- Give birthing person a chance to consider and consent before continuing talking or acting

Recommendations for Hospital Systems

- Provide education for hospital staff on midwives and community birth
- Provide education for pediatricians on midwife newborn scope of care
- Provide training for staff on informed choice, respectful care, and empathy
- Create clear communication protocols for incoming transfers
- Create protocols so that community birth transfers can go straight to L&D not the ED
- Improve inpatient postpartum with a focus on respect, informed choice, and minimizing disruptions during rest
- Increase postpartum care and support after discharge for all families
- Change hospital rooms to be more comfortable and feel less medical

- Create policies and physical areas for birthing people go outdoors during labor

Collaborative Recommendations

- Hospital providers and community meet regularly to build relationships
- Community midwives and hospital providers work on clear communication about level of urgency of care
- Community midwives and hospital work together on communication with EMS
- Provide continuing education for community midwives on cesarean recovery

System-Level Recommendations

- Mandate full insurance coverage for midwives, birth centers, and home birth
- Financially de-incentivize cesarean section

Report compiled by Silke Akerson.

Appendix D: Smooth Transitions™ Materials

Information Sheet

History

The Smooth Transitions™ Quality Improvement Program was originally conceived, under the auspices of the Washington State Perinatal Collaborative, as an initiative to enhance the safety of hospital transfers from planned community-based births. In 2009, the MD/LM Workgroup, a subcommittee of the WA State Department of Health Perinatal Advisory Committee, introduced the program to assist hospitals providing obstetrical services in developing clear protocols to facilitate seamless transfers of care when those planning a home or birth center birth need to access hospital services or their newborns need hospital-based care. The goals of the program are to:

- Improve the safety and efficiency of the transfer process through the establishment of system-wide protocols
- Collect and analyze transfer outcome data for the purpose of quality improvement
- Build greater collaboration between community midwives, EMS, and the hospital care team
- Enhance the patient experience of care when transfers occur

Since January 2018, Smooth Transitions has been under the umbrella of the Foundation for Health Care Quality (FHCQ), a 501(c)3 organization in Seattle that houses several other quality improvement programs, including the Obstetrical Care Outcome Assessment Program (OB COAP). This move to the FHCQ re-energized and re-focused the program. Smooth Transitions now has more administrative support, a more prominent web presence, CQIP status (which will allow for inter-professional protected case review), and the potential for more sophisticated data collection and analysis. In addition, an enthusiastic, multidisciplinary workgroup oversees the program and we have financial and in-kind support from a number of stakeholder groups, including the Washington State Hospital Association, the Washington State Obstetric Association, the state affiliate of the American College of Nurse-Midwives, and the Midwives' Association of Washington State, as well as a grant from the American Institute for Research.

Nearly a third of the hospitals throughout the state have received presentations. The Smooth Transitions leadership team has also presented at a number of perinatal collaborative meetings in other states and at the International Confederation of Midwives Triennial Congress in Toronto. Participating hospitals in Washington are engaged at various levels: some have only received an initial presentation; others have formed Perinatal Transfer Committees, developed

clear transfer protocols and are meeting regularly with local community midwives, problem-solving together, and collecting data.

How To Get Started

Hospitals interested in learning more about the Smooth Transitions™ QI Program should contact the Program Coordinator (smoothtransitions@qualityhealth.org) to set up a 90-minute informational meeting with your obstetrical services team to introduce the program. At this meeting, two representatives from the Smooth Transitions Workgroup (usually an OB and a licensed midwife) will co-present and answer questions about the program; then, if the hospital decides to move forward with next steps, the Program Coordinator will be available to provide ongoing consultation and support throughout the process.

The expectation is that each participating hospital will identify clinician champions, both in the hospital and in the midwifery community, and set up a Perinatal Transfer Committee. This committee ideally will include obstetrical staff, OB nursing leadership, pediatric staff, and representatives from patient safety/risk management departments, as well as local EMS providers and licensed midwives who transfer to that hospital. At a minimum, the Perinatal Transfer Committee develops and adopts a transfer protocol, transfer forms, SBAR scripts, and a transfer algorithm. This committee will meet 2 – 3 times/year to discuss any issues or concerns regarding transfers and to share strategies about how to improve efficiency, safety, and satisfaction. Both quantitative and qualitative data are collected on the transfers and then discussed at the Perinatal Transfer Committee meetings. Participating hospitals are also asked to submit a brief annual report to the Smooth Transitions Workgroup about the program's impact. If needed, one benefit of program participation is the ability to engage in a protected case review process under the Department of Health's Coordinated Quality Improvement Program (CQIP).

Smooth Transitions Program Steps

1. **Host a Smooth Transitions™ Presentation**
   The Smooth Transitions Program Coordinator sets up a presentation at your hospital. Beforehand, the Program Coordinator talks with hospital staff and community midwives about the current situation and issues.
2. **Identify Clinician Champions**
   It is important to find a clinician champion for both the hospital and midwifery community. They will help organize meetings and communicate between the groups.
3. **Form a Perinatal Transfer Committee**
   Gather a group of obstetrical and pediatric providers, nursing staff, EMS personnel, and local community midwives and form a perinatal transfer committee.
4. **Develop and Adopt Transfer Tools**
   The Transfer Committee creates a transfer protocol, and adopts transfer forms, SBAR scripts and a transfer algorithm using provided templates.
5. **Meet Regularly/Interaction**
   The Perinatal Transfer Committee meets at least 2 – 3x/year to discuss any issues or concerns regarding transfers and to share strategies about how to improve efficiency, safety, and satisfaction. This can also be an opportunity to share CME, skills training,

and resources. Protected case reviews can occur as needed following the Smooth Transitions Protocol.

6. **Collect Data and Publish Research**
   Participating hospitals will collect data to evaluate the efficacy of the project. Quantitative and qualitative analysis can be done for small scale improvement at the hospital level or statewide for research purposes and publication.

Smooth Transitions Template Protocol

Hospital Transfer from Planned Community Birth

Please customize this protocol according to your hospital. The protocol is a place to clarify the process of transfer and meet everyone's needs: receiving provider and transferring midwife, while keeping the patient/client at the center. As the protocol is being used, make modifications as needed to maximize efficiency, safety, and satisfaction.

1. Community midwives will encourage their clients to:
   - pre-register with the local hospital several months prior to their due date
   - take a tour of the local hospital
   - draft a birth plan in the event of hospital transfer

2. The community midwife will contact the hospital through the designated route and notify the receiving provider of an incoming transfer from a planned community setting. *Each hospital will have their unique way to access appropriate care. List those details, including phone numbers, here.* The community midwife's communication will include the name, age, G/P and DOB of the patient, reason for transfer, relevant clinical background information, the condition of mother and/or baby, the planned mode of transfer, and the expected time of arrival. *Any other patient information can be specified in the protocol. An SBAR script is helpful here.*

3. The receiving provider will then convey this information to the NTL (nurse team lead/charge nurse) who will facilitate a direct admission so that the patient can be brought to a labor room upon arrival.

4. The community midwife will provide relevant medical records at the time of transfer which will be placed in the patient's chart. *Transfer forms may be used as well*. Records may be faxed, sent electronically, or brought in and photocopied. *Please list fax numbers or other details around records here.*

5. If possible, the licensed midwife will accompany her client to the hospital to facilitate a smooth transfer of care. At the hospital, **prior to initiating care**, the receiving provider will meet with the community midwife along with the NTL and the bedside nurse assigned to the patient, to discuss the patient's care, plan of action, and answer questions. The community midwife will then introduce the hospital care team to her client.

6. The hospital care team recognizes the community midwife as the patient's primary care provider who has an established relationship with the patient. We encourage the community midwife to join with the hospital care team to provide ongoing support and care of the patient.

7. The hospital care providers (OB hospitalist, CNM, pediatric hospitalist) will coordinate with the community midwife a schedule of follow-up care for the patient and/or her baby.

8. The discharging provider will request that relevant hospital records are sent to the community midwife, so they are available for review prior to follow-up with the patient. *Outline the discharge records process here.*

9. The community midwife, receiving hospital provider, nursing staff (ideally the NTL and bedside nurse), and the client will fill out their appropriate Smooth Transitions™ surveys and data collection tools. If EMS was involved, they have a survey to fill out as well.

	Antepartum		Intrapartum		Postpartum (Maternal)		Newborn	
	Non-Urgent*	Urgent**	Non-Urgent*	Urgent**	Non-Urgent*	Urgent**	Non-urgent*	Urgent**
General Information								
Who is the contact at the hospital for general issues regarding OOH transfers?								
Transfer Process								
Will the hospital accept transfer of these patients from OOH providers?								
What telephone number should the OOH provider call to communicate directly with the receiving department or provider?								
To whom should the OOH provider ask to speak?								
Other information or instructions								
In addition to the UWNQC transfer forms and the relevant medical records, is there anything else the OOH provider should routinely provide?								
Which department should the patient go?								
In addition to the OOH provider, how many people may accompany the patient?								
Anything else?								
Post-Transfer Communication								
How will the hospital provider report back to the OOH provider on the patent's hospital course?								

*Non-urgent is defined as a condition where the patient needs medical attention, but the situation is not life-threatening, and a delay of up to hours is not likely to significantly affect the outcome.

**Urgent is defined as a condition where the patient needs immediate medical attention to prevent serious injury or death.

Smooth Transitions Transfer Log

Hospital: ____________________

Year ______________

date	client ID	MW	hosp provider	911	G/P	*timing	reason/s for transfer	^outcome	#surveys

*timing: when does the transfer occur? antepartum, intrapartum (1st or 2nd stage), immediate postpartum (mom or baby or both)

^outcome: this is a place to note what happened? NSVD, C/S, NICU or ICU admission, epidural, augmentation, etc.

#surveys: to be done by community midwife, client, receiving provider, nursing staff, and EMS if it was used

SBAR Script for Phone Call Received re: Transfer from Home Birth

Name/Credentials of Hospital Staff receiving call: _____

Name & credential/relationship of caller: _____

Date: _____ Time of Call: _____ Call Back Number: _____

Mother's Name: _____ DOB: _____

□ G, P: _____ EDD: _____ Number of weeks pregnant _____

Situation:

Transfer for □ mother □ baby □ mother and baby
From a planned: home birth birth center
Reason for Transfer: _____

_____

Client's Location: _____

Who will accompany the client? _____

Mode of Transportation**:** _____ ETA: _____

Medical Records at this hospital? □Unknown Yes No

Background: Relevant prenatal, labor and birth or newborn information, interventions that have been initiated:

_____
_____
_____

Assessment:

Mother current condition: Stable
Unstable (specify) _____
Baby current condition: Stable
Unstable (specify) _____

Recommendation:

Care plan and personnel likely needed on arrival: _____

_____

Checklist:

□ Received call from transferring provider, documented times and completed form

□ Inform consulting physician(s) or receiving CNM (SBAR) of situation/urgency and ETA

□ Inform admitting of situation and ETA

□ Arrange for equipment, room and staff required

□ Meet and welcome woman and home care team in assessment room

□ Antenatal and intrapartum records received from transferring provider: □Copy placed in chart

□ Other:

_____

911 Protocol (LM audience)

1. Community midwife calls 911 and works through dispatch to initiate "medical" care. Midwife states the emergency (short report)

   "I am a licensed midwife and I have a mother/infant who is/has _____.

   The patient is stable but according to our protocol we need to transfer to the hospital.

   OR

   This is a life-threatening emergency.

   And I need advanced life support (ALS) at address."

   If the midwife has a plan already in place to transfer the patient to a particular hospital, it would be helpful if that was stated now.
2. Midwife directs someone on scene to look for and direct the emergency responders into the house and room.
3. When the first unit arrives, Identify yourself as the LM and state you have information about the patient/emergency. Ask for the patient lead and give the short report which should include: relevant medical history, birth history, presenting concern, contact with local hospital/provider, midwife's plan for intervention/continuing care, and anything else that seems important. SOAP format is helpful.
4. Midwife can direct patient lead to patient chart for more information, if that's applicable.
5. At this point EMS will likely arrive on scene and the first crew will be able to communicate the situation with input from the midwife. A transfer of care will occur now but there is an opportunity for the midwife to provide support for the patient and/or the EMS providers as needed.
6. The determination needs to be made whether the midwife will accompany the patient in the aid car or come in her own vehicle to the hospital.
7. Upon arrival at the hospital, the midwife will proactively include herself in the hospital care team.

Appendix E

Midwife Credential Comparison

Clinical and Educational Requirements

	Certified Professional Midwife CPM	**Certified Nurse Midwife CNM**	**Naturopathic Physician** with Natural Childbirth Certificate (Oregon)
Births attended *	55	20	50
Out-of-hospital births	10	No requirement	No more than 10 can be planned hospital births
Prenatal exams	100	85	150
Newborn exams	40	20	No requirement
Postpartum exams	50	35	100
Clinical hours	1350 hours of clinical training under supervision	No specific requirement for the credential. Programs are frequently 600-1000 hours	No specific requirement
Clinical skills and knowledge	NARM Job Analysis Core Competencies for Midwifery Practice	ACNM Core Competencies for Basic Midwifery Education	Not specifically defined
Degree requirement	No degree requirement. Competency-based certification. Many programs grant bachelor's or master's degrees.	Graduate degree	Graduate degree 200 hours of coursework specific to obstetrics
Education Program Accrediting Organization	Midwifery Education and Accreditation Council (MEAC)	Accreditation Commission for Midwifery Education (ACME)	Council on Naturopathic Medical Education
Certification exam	NARM exam	AMCB exam	OBNM Natural Childbirth exam
Recertification and continuing education requirements	30 hours every 3 years	20 hours and 3 AMCB Certificate Maintenance Modules or retake certification exam every 5 years	15 hours every year

* For reference, the birth requirement for family practice physicians is 40.

1) North American Registry of Midwives
http://narm.org/certification/how-to-become-a-cpm/
2) American Midwifery Certification Board
https://www.amcbmidwife.org/amcb-certification/candidate-handbook
3) Oregon Board of Naturopathic Medicine
https://www.oregon.gov/obnm/pages/natural-child-birth.aspx

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