

The Arizona Section of the American Congress of Obstetricians and Gynecologist



**TRANSPORT SAFETY RELEVANT TO
HOME BIRTHS AND THE
PROVIDERS WHO GIVE
MATERNITY CARE**

**MARIA MANRIQUEZ, M.D. FACOG
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Primary outcome goal



A pregnancy, delivery and post-partum period that is safe for the mother and the infant

Informed Decision Making



- ACOG supports informed decision-making by women about their care options
- As physicians, we inform, educate and respect our patients' care choices
- All women should receive information regarding the **risks, limitations and advantages of their care locations, care practices and their maternity care provider**

Providers



- **Licensed midwives or direct-entry midwives,** do not require prior training in nursing
 - AZ requirements are currently 18yo age, be of good moral character, high school diploma or GED, basic CPR and NRP certified. *Draft proposal - 21yo, certified by North American Registry of Midwives (minimum of 25 birth as primary)*
- **Certified nurse midwives**
 - Require undergraduate degree in nursing, followed by postgraduate program at Master degree level
- **Obstetricians**
 - Undergraduate degree, Medical Diploma, and four year training program requiring as absolute minimum of 200/145/15 numbers

Integrated Systems



- ACOG supports the *collaborative practice model*, the maternity care team, and integrated systems of care with established criteria and provision for emergency intrapartum transport
- Childbirth has become safer for mothers and babies because of improvements in medical technology and access to trained providers and emergency obstetric and neonatal care.

Integrated Care



- At anytime during pregnancy and the birth process women may encounter complications requiring a change of provider or setting
- An *integrated system* must facilitate timely communication and transfer of collaborative management of care
- An integrated system depends on appropriately trained and certified practitioners at all levels, open communication and transparency, ongoing performance evaluation, use of evidence-based guidelines and patient education

Integrated Care



- Should women choose home birth, it should be attended by appropriately trained health care providers in a transparent continuum of care under guidelines that attempt to make birth as safe as possible in that setting for the best possible outcome for mothers and neonates
- The home birth attendant must have a system in place where consultation with hospital-based and privileged consultants can occur expeditiously in the prenatal, intrapartum, and postpartum periods to guarantee safe and expeditious transfer of care and transport to a hospital for optimal continuity of care

Who is Low Risk?



- **Uneventful antepartum period**
- **Spontaneous labor between 37 and 42 completed weeks of pregnancy**
- **Cephalic presentation**
- **Previously uncomplicated pregnancy**

Who is High Risk?



- **VBAC**
- **Multiple Gestation**
- **Birth under 37 weeks or after 42 weeks**
- **Placental abnormality**
- **Non-Cephalic Presentation**
- **Preeclampsia/Eclampsia**
- **Gestational Diabetes**
- **Previous major surgery of the pulmonary, cardiac, GU or GI system**
- **Pre-existing medical conditions: diabetes, HTN, cardiac disease, renal disease, etc**

Situations that may be catastrophic



- Selecting candidates for Home Birth on the basis of Low Risk status, **will not protect** patients from unpredictable and potentially catastrophic emergencies
- Such emergencies are best managed by the personnel and resources only available in the Hospital setting
- Emergency transport from home to such facilities may not provide timely and effective interventions to avoid serious or fatal outcomes

Situations that may be catastrophic



- **Shoulder Dystocia** - Head delivers but shoulders get stuck in the pelvis
- **Prolapsed cord** - Baby's cord comes out before the baby's head and this can obstruct the baby's blood supply
- **Placental Abruptio** - Placenta separates before birth and this leads to bleeding from the mother and decreased oxygen to the baby
- **Post partum Hemorrhage** – acute, severe bleeding after birth

Risks of Home Birth May Be Reduced As Long As:



- There are enforced criteria to determine who is a low risk candidate for home birth and who needs consultation or transfer prior to birth or during the birthing process
- There are agreed upon practice guidelines for all health care providers necessary to achieve safe motherhood
- There are collaborative practice agreements guaranteeing smooth transition of care in the event of an emergency that clearly spell-out mechanisms for consultation, collaboration, and referral or transfer of care
- Distance and transportation from home to hospital are not impediments to timely care

Standard of Practice Requirements to Enhance Safety



Detailed Requirements for Standards of Practice should be adopted. At a minimum these should include:

- Informed Consent
- Criteria for Selection of Clients
- Client care plan including ongoing risk assessment to continuously assess normalcy
- Delineate maternal and newborn conditions requiring physician consultation, referral and transfer of patient care for all stages of care including antepartum, intrapartum, postpartum and newborn management and referral
- Peer review
- Protocols for medication and equipment use

Outcomes Reporting and Data Collection



- Accurate collection and reporting of safety statistics and birth outcomes in different birth settings is critical
- Home birth providers should be required to report birth and fetal deaths so that they are included in the State FIMR program
- Data collection system for home birth statistics should be developed.
- Home birth providers should be required to file birth certificates

VBAC



- 60-80% of women attempting a trial of labor after one prior C-section will be successful
- The risk of uterine rupture during a trial of labor in women with one prior low transverse C-section is 0.5-0.9%
 - Women with two prior C-sections have a rupture rate of 0.9-3.7%
- **Uterine rupture is often sudden and can be catastrophic – accurate antenatal predictors of uterine rupture do not exist**
 - 70% associated with a fetal heart rate abnormality – supports continuous fetal monitoring
- ACOG recommends that a trial of labor be undertaken in a **facility with staff immediately available to provide emergency care**

Smooth Transitions: Enhancing the Safety of Planned Out-of-Hospital Birth Transport



- Physician-Licensed Midwife Work Group
- Planned Out-of-Hospital Birth Transport Guidelines
 - WA professional liability insurance companies who provide obstetrician professional liability insurance ask the insured not form a formal written consultation agreements with licensed midwives, which may be interpreted as the “loaning” of the physician’s liability policy.
 - AZ rules are at least if not more stringent
 - ✦ “MICA does not insure Licensed Midwives directly or indirectly as additional insureds employed by physicians or physician groups nor does MICA knowingly insure physicians who supervise or coordinate care provided by Licensed Midwives.”

Liability Insurance



- LM's may choose to obtain liability insurance through a state-mandated program, the Joint Underwriting Association (JUA), Redmond, WA
- www.washingtonjua.com
- 68 of the 109 (62%) LM's in WA are insured by the JUA
- Some of the 41 LM's not insured through the JUA may have purchased other coverage
- All 13 licensed freestanding birth centers in WA have liability coverage through the JUA

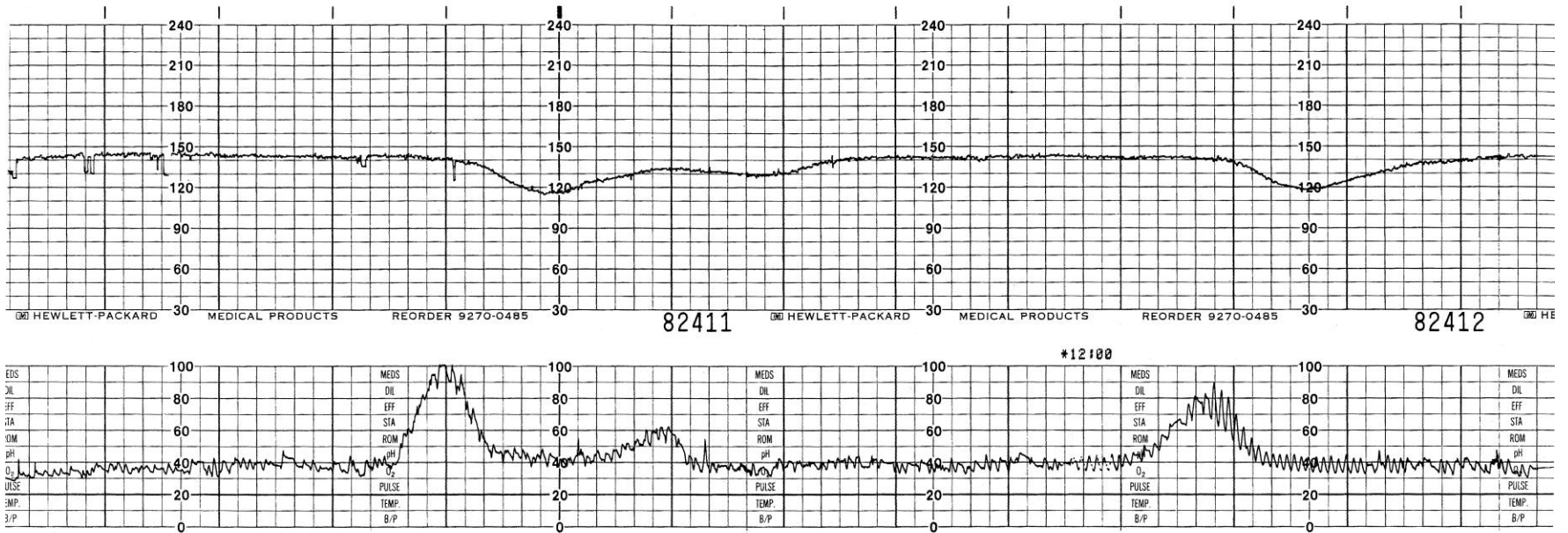
Incorporating Planned Out-of-Hospital Birth Transfer Quality Improvement Project



- Arizona Perinatal Trust
- Hospital Sanctioned
- See Appendix A of Smooth Transition Project Manual
- Elements of Good Transfer
 - Communication
 - Excellent Documentation
 - Role change of midwife from primary care provider to companion/support person. Respectful recognition of all parties' role facilitates patient safety and satisfaction.
 - Post delivery surveys – (patient, licensed midwife, nursing staff, and physician) feedback on transfer and areas needing improvement
 - Discharge summary copied to licensed midwife and where appropriate patient should return to licensed midwife for postpartum care

Intrapartum Fetal Surveillance

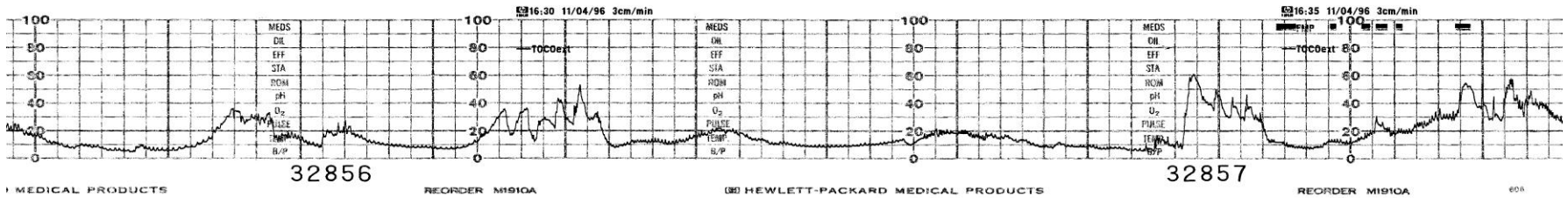
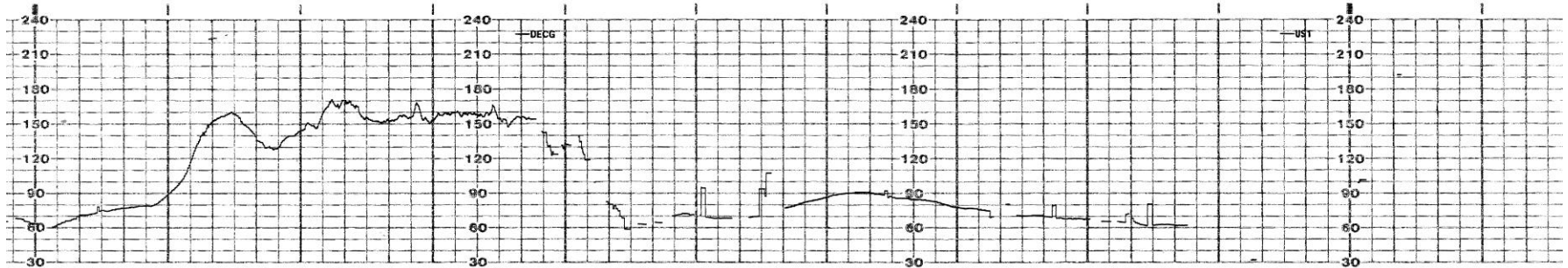
Case # 10



Gravida 3, Para 2 in spontaneous labor at term with cervix 6 cm dilated.

Intrapartum Fetal Surveillance

Case #10



MEDICAL PRODUCTS

32856

REORDER M1910A

HEWLETT-PACKARD MEDICAL PRODUCTS

32857

REORDER M1910A

60A

Home Birth – Proceed With Caution



“Women have the right to choose how and where to give birth, but they do not have the right to put their baby at risk”

Lancet 2010;376:303

References



- ACOG Practice Bulletin – VBAC
- ACOG Committee Opinion – Planned Home Birth
- Smooth Transition – Project Manual
 - Robert Palmer, MD Co-Chair, Washington State ACOG
 - Audrey Levine, LM, Co-Chair, Midwives' Association of WA
- Planned home birth: the professional responsibility response *Am J Obstet Gynecol* 2013 Jan:208