

## **Minnesota Council of Certified Professional Midwives (MCCPM)**

### **INDICATIONS FOR CONSULTATION, REFERRAL, AND TRANSFER OF CARE IN OUT OF HOSPITAL (HOME AND BIRTH CENTER) MIDWIFERY PRACTICE**

Based on the Midwives Association of Washington State Indications for Discussion, Consultation, and Transfer of Care in a Home or Birth Center Midwifery Practice

#### **1. INTRODUCTION:**

Professional members of the Minnesota Council of Certified Professional Midwives (MCCPM) include Licensed Midwives (LMs), Certified Professional Midwives (CPMs) and Certified Nurse Midwives (CNMs). In the home or birth center setting LMs and CNMs (herein referred to as ‘Midwives’) work interdependently with one another and with other health care practitioners to promote the optimal health and safety of low-risk pregnant people and babies during the normal childbearing cycle. Midwives engage in an ongoing risk screening process that begins at the initial visit and continues through the completion of care. In providing care, midwives take into account their clinical judgment and expertise, a client's own values and informed choice, relevant state laws and regulations, the standards for practice and core competencies for basic midwifery care provided by their professional organizations, relevant midwifery and medical literature, the settings in which they practice, the collaborative relationships they have with other health care practitioners and area hospitals, and their philosophy of care.

During pregnancy, labor, or postpartum, risk factors or complications can develop. This document provides a list of conditions that a midwife may encounter in practice for which consultation, referral, or transfer of care is indicated. The list is representative but not exhaustive. Other circumstances may arise where the licensed midwife believes consultation, referral, or transfer of care to be necessary.

Professional members of the Minnesota Council of Certified Professional Midwives are advised to discuss, consult, and/or transfer care of their clients according to this document and in accordance with the MCCPM Position Statement: Shared Decision-Making. MCCPM recognizes that there are variations in practice specialty and professional members may hold different licenses or qualifications which hold them to a different standard of care than those outlined in this document. (These practitioners may include but are not limited to CNMs, ARNPs, and NDs). MCCPM members should discuss the scope and limitations of midwifery care with clients and refer to these documents as necessary.

This document should be used as a screening tool to distinguish between low-risk and higher-risk maternal and newborn clients. Its purpose is to enhance safety and promote midwives' accountability to their clients, to one another, to other health care practitioners, and to the general public. MCCPM reviews this document periodically and revises it as necessary in order to reflect the most current evidence available and to insure that the parameters identified promote the safety of birthing person and newborn without unduly restricting midwifery practice.

#### **2. DEFINITIONS:**

##### **2.1 CONSULTATION WITH ANOTHER MIDWIFE, AN APRN, OR A PHYSICIAN**

A consultation refers to a situation in which the midwife seeks information from a colleague about a clinical situation, presenting a management plan for feedback. (A MCCPM member who has additional credentials (i.e.: CNM, ND) that allow for a broader scope of practice need not discuss conditions that are within their scope of practice.)

- 2.1.1 It is the midwife's responsibility to initiate a consultation with and provide accurate and complete clinical information to another midwife, a nurse practitioner, or a physician in order to plan care appropriately. This consultation can take place between midwives in the same practice.

- 2.1.2 Consultation should occur in a timely manner soon after the clinical situation is discovered.
- 2.1.3 Consultation may occur in person, by phone, fax, or e-mail.
- 2.1.4 Consultation may include review of relevant patient records.
- 2.1.5 Consultation may include request for prescriptive medication based on signs or symptoms and/or laboratory results.
- 2.1.6 Consultation should be documented by the midwife in the client's records. Documentation of consultation should refer only to practitioner type without specifying the name of the practitioner contacted. Documentation should also include the midwife's management plan.
- 2.1.7 Consultation need not occur if the midwife has previously encountered a particular situation, discussed it with a colleague, developed a management plan, and is currently managing the same clinical presentation. In this case, documentation of the management plan and discussion with the client of the management plan is sufficient.

## 2.2 REFERRAL TO AN APRN or PHYSICIAN

A referral refers to a situation in which the midwife, using professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of an APRN or physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the referral.

- 2.2.1 It is the midwife's responsibility to initiate a referral and to communicate clearly to the consultant that the midwife is seeking a referral.
- 2.2.2 A referral can involve the APRN or physician providing advice and information, and/or providing care to the client/newborn, and/or prescribing treatment for the client or newborn.
- 2.2.3 In the case of an in-person referral, the midwife should expect that the consultant will promptly communicate findings and recommendations to the client and the referring midwife after the referral has taken place.
- 2.2.4 Where urgency, distance, or climatic conditions do not allow an in-person referral to an APRN or physician when it would otherwise be appropriate, the midwife should seek advice from an APRN or physician by phone or other similar means. The midwife should document this request for advice in the client's records and discuss the consultant's advice with the client.
- 2.2.5 It is the midwife's responsibility to provide all relevant medical records to the consultant, including a written summary of the client's history and presenting problem, as appropriate.
- 2.2.6 The referral should be fully documented by the midwife in the client's records, including the consultant's name, date of referral, and the consultant's findings, opinions, and recommendations. The midwife should then discuss the consultant's recommendations with the client.
- 2.2.7 After a referral with an APRN or physician, care of the client and responsibility for decision-making, with the informed consent of the client, either continues with the midwife, is shared collaboratively by the midwife and the consultant, or transfers completely to the consultant. Transfer or sharing of care should occur only after dialogue and agreement among the client, the midwife, and the consultant. (During such collaborative care the consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within the midwifery scope of practice. It is the midwife's responsibility to maintain explicitly clear communication between all parties regarding which health professional has primary responsibility for which aspects of the client's care. In addition to any verbal dialogue regarding client care, the dialogue and plan of care should be documented in the client's chart.)

### 2.3 TRANSFER TO A PHYSICIAN OR OTHER QUALIFIED HOSPITAL-BASED PROVIDER

When care is transferred permanently or temporarily from the midwife to a qualified hospital-based provider, the receiving practitioner assumes full responsibility for subsequent decision-making, together with the client. For guidance about intrapartum transfers, see also the Home Birth Summit Transport Guidelines.

## **3. INDICATIONS**

### 3.1 PRE-EXISTING CONDITIONS AND INITIAL HISTORY

Consultation with another out of hospital based midwife:

- History of two or more pre-term births (<36 weeks)
- History of two or more low birth weight babies (less than 5 lbs)
- History of IUGR
- History of difficulty controlling hemorrhage with previous births, miscarriages and/or abortions, or severe postpartum hemorrhage requiring transfusion
- History of severe pre-eclampsia
- No prenatal care prior to third trimester
- History of lap band, gastroplasty or other bariatric (weight loss) surgery
- Previous unexplained neonatal mortality or stillbirth
- History of cesarean
- History of 3 consecutive spontaneous abortions (excluding clients who present to care with viable pregnancy at gestation >14wks)
- Regular tobacco or marijuana use, abuse, or dependency
- No care established by 28 weeks by any maternity care provider
- Family has not initiated care with attending midwife by 36 weeks

Consultation with an APRN or Physician:

- History of eclampsia or HELLP
- Significant uterine or vaginal anomalies
- Current managed severe psychiatric illness (consultation with managing provider)

Referral to an APRN or Physician:

- History of seizure disorder in adulthood
- History of uterine surgery (including myomectomy) other than cesarean or D&C
- Significant history of cardiovascular, renal, hepatic, neurological or severe gastrointestinal disorder or disease
- Significant history of or current endocrine disorder (excluding controlled mild thyroid disorder and polycystic ovarian syndrome)
- Collagen vascular diseases
- Significant hematological disorders, such as Sickle Cell disease
- Current or recent diagnosis of cancer requiring chemotherapy
- Isoimmunization with an antibody known to cause hemolytic disease of the newborn
- History of cervical cerclage
- Current seizure disorder
- Maternal HIV infection
- Marked skeletal abnormalities that would interfere with the birthing process
- History of thromboembolism
- History thrombophlebitis

Contraindication for out of hospital birth:

- Absent prenatal care at term
- Current cardiovascular, renal, hepatic, neurological or severe gastrointestinal disorder or disease
- Pulmonary disease/active tuberculosis/severe uncontrolled asthma

- Essential hypertension
- Current unmanaged severe psychiatric illness
- Insulin dependent diabetes mellitus
- Prior cesarean with incision other than low transverse (e.g. classical)
- Regular alcohol use or drug use, abuse, or dependency other than tobacco or marijuana
- Unmanaged seizure disorder
- Systemic Lupus
- Unwillingness to accept midwife's limitations, prohibitions, and responsibilities for safe practice

### 3.2 ANTEPARTUM CONDITIONS

Consultation with another out of hospital based midwife:

- 42 weeks with reassuring fetal surveillance including AFI and BPP
- Presentation other than cephalic at 37 weeks or later
- Multiple gestation with Dichorionic-Diamniotic twins

Consultation with a APRN or Physician:

- Urinary tract infection unresponsive to treatment
- Reportable sexually transmitted infection
- Significant abnormal pap
- Significant abnormal breast lump
- Pyelonephritis
- Fetal demise after 14 weeks gestation
- Primary herpes infection
- Hemoglobinopathies
- Molar pregnancy

Referral to an APRN or Physician:

- Ultrasound finding of two vessel cord
- Suspected size/dates discrepancies for 2 consecutive prenatal visits (ultrasound evaluation meets this requirement)
- 42 weeks with non-reassuring fetal surveillance and/or BPP score of 6/8 or less
- Thrombosis or thrombophlebitis
- Hemoglobin less than 10, unresponsive to treatment
- Signs indicative of placental abruption
- Abnormal vaginal bleeding before onset of labor
- Platelets  $\leq 100,000/\mu\text{L}$
- Persistent abnormal fetal heart rate or rhythm
- Non-reassuring fetal surveillance
- Ectopic pregnancy
- Isoimmunization with an antibody known to cause hemolytic disease of the newborn
- Observed maternal cardiac irregularities
- Marked decrease or cessation of fetal movement (at minimum order a BPP)
- Suspected cholestasis
- Maternal respiratory distress
- Indications that the baby has died in utero

Contraindication for out of hospital birth:

- Failure to document basic prenatal lab work (blood group and type, Rh antibody screening, hemoglobin around 28 weeks gestation) or signed refusal
- Hemoglobin less than 9 at 36 weeks (can return to out of hospital midwifery care if above 9 by onset of labor)
- Rubella during the first trimester
- Placental abruption
- Significant or unresolved polyhydramnios or oligohydramnios
- Multiple gestation with anything other than Dichorionic-Diamniotic twins

- Rupture of membranes or labor prior to 36 weeks gestation
- Documented persistent/unresolved intrauterine growth restriction/small for gestational age (IUGR/SGA)
- Eclampsia, HELLP, pre-eclampsia, or persistent hypertension
- Placenta previa at term
- Placental located over previous uterine scar
- Deep vein thrombosis
- Cholestasis
- Cardiac or renal disease with failure
- Gestational diabetes requiring management with medication
- Serious viral/bacterial infection at term
- Known fetal anomaly or condition that requires physician management during or immediately after delivery
- 43 weeks 0 days completed gestation
- Client's desire for transfer
- Any other condition or situation based on the midwife's clinical judgement

### 3.3 INTRAPARTUM CONDITIONS

In certain intrapartum situations, the midwife may need to act immediately and transport may not be the most prudent course of action in that moment. It is expected that the midwife will utilize clinical judgment and expertise in such situations, access 9-1-1 and emergency services as appropriate, and transport as able.

Consultation with another out of hospital based midwife:

- Active labor between 36 weeks 0 days and 36 weeks 6 days
- Undiagnosed non-cephalic presentation including breech or compound presentation at onset of labor
- Prolonged rupture of membranes (>48 hours without active labor)
- Rupture of membranes > 18 hours with GBS status unknown and no prophylactic antibiotics, or GBS+ and no prophylactic antibiotics
- Active pushing longer than 4 hours during a primipara labor without significant change or 3 hours during a multiparous labor without significant change

Consultation with a APRN or Physician:

- Prolonged rupture of membranes (>72 hours without active labor)

Transfer:

- Undiagnosed non-cephalic presentation including transverse lie or oblique lie at onset of labor (not including breech or compound presentation)
- Maternal fever ( $\geq 100.4$  F) that persists more than one hour
- Findings indicative of chorioamnionitis including, but not limited to, maternal tachycardia, fetal tachycardia, temperature  $\geq 100.4$  F, uterine tenderness, purulent or malodorous amniotic fluid.
- Thick meconium and deviations in FHTs (if the expected time of birth is greater than the projected transport time)
- Persistent non-reassuring fetal heart rate pattern
- Maternal exhaustion unresponsive to rest/hydration
- Abnormal bleeding during labor
- Suspected placental abruption
- Suspected uterine rupture
- Maternal respiratory distress
- Hypertension ( $\geq 140$  systolic or 90 diastolic twice 1 hour apart)
- Suspected pre-eclampsia
- Maternal seizure
- Prolapsed cord or cord presentation
- Significant allergic response
- Chest pain or other signs of cardiac arrest
- Client's desire for transfer
- Any other condition or situation based on the midwife's clinical judgement

### 3.4 POSTPARTUM CONDITIONS

#### Consultation with a APRN or Physician:

- Urinary tract infection unresponsive to treatment
- Mastitis (including breast abscess) unresponsive to treatment
- Reportable sexually transmitted infections
- Significant abnormal Pap

#### Referral to an APRN or Physician:

- Retained products/unresolved subinvolution/prolonged or excessive lochia
- Hypertension ( $\geq 140$  systolic or 90 diastolic twice 1 hour apart) presenting beyond 72 hours
- Failure of laceration to heal properly or signs of infection unresponsive to treatment
- Significant postpartum depression
- Lacerations beyond midwife's ability to repair (repair may be made in the OOH setting by another provider if the repair is within their ability and expertise to repair, otherwise transfer to the hospital is indicated; repair should take place during the immediate postpartum period, ideally within 6 hours of birth)

#### Transfer:

- Significant postpartum hemorrhage unresponsive to treatment, with or without sustained maternal vital sign instability or shock
- Retained placenta ( $> 2$  hours or active bleeding and manual removal unsuccessful)
- Unusual or unexplained significant pain or dyspnea
- Significant, enlarging hematoma
- Endometritis
- Maternal seizure
- Anaphylaxis
- Persistent uterine prolapse or inversion
- Maternal fever ( $\geq 100.4$  F) that persists  $> 1$  hour within the first 72 hours postpartum
- Persistent hypertension in the first 72 hours postpartum ( $\geq 140$  systolic or 90 diastolic twice 1 hour apart)
- Postpartum psychosis
- Any other condition or situation based on the midwife's clinical judgement

### 3.5 NEWBORN CONDITIONS

It is recommended that parents choose a pediatric provider before the baby is born. It is recommended that parents be advised to establish care with a pediatric provider by 2 weeks of age. The following conditions warrant contact sooner.

#### Consultation with another out of hospital based midwife:

- Failure to pass meconium within the first 24 hours
- Inability of newborn to feed well due to lethargy

#### Consultation with a APRN or Physician:

- Low birth weight newborn ( $< 2500$  gm = 5 lbs 8 oz)
- Unresolved abnormal cry in newborn, such as weak or high pitched
- Loss of greater than 10% of birth weight
- Prolonged asymptomatic jaundice
- Failure to pass urine within the first 24 hours or failure to pass meconium within the first 48 hours

#### Referral to an APRN or Physician:

- Persistent cardiac arrhythmias or murmurs
- Significant clinical evidence of prematurity
- Failure to thrive
- Significant or symptomatic jaundice beyond the first 24 hours
- Two vessel cord
- Signs of umbilical infection unresponsive to treatment

Transfer:

- Hypoglycemia unresponsive to treatment
- Positive critical congenital heart disease screening (CCHD)
- Seizure
- Jaundice in the first 24 hours
- Persistent respiratory distress
- Persistent central cyanosis or pallor
- Persistent temperature instability
- Temperature of 100.4°F or greater, two consecutive readings 30 minutes apart
- Apgar score 6 or less at ten minutes of age
- Major congenital anomalies affecting well-being
- Birth injury requiring medical attention
- Client's desire for newborn transfer
- Any other condition or situation based on the midwife's clinical judgement