Chapter 4
From Home to Hospital: Sustainable Transfers of Care in the United States

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4.1 Introduction

Rapport matters in patient–provider relationships, and continuity of care improves outcomes for both mothers and neonates (McLachlan et al. 2012). Over the course of many visits, a client may become more willing to disclose concerns and more trusting of the provider’s clinical judgment. Yet for spontaneous vaginal deliveries within US hospitals, a patient may have little choice about who attends her birth. Indeed, this disconnect prompts a familiar refrain, “Oh, I hope I get my doctor when it’s time for the baby to be born.”

A shift in the practitioner attending a birth may be relatively common, but a shift in the site of delivery is not. A transfer of care from home to hospital—and potentially involving a different care team—brings a host of new concerns and costs, financially, logistically, and emotionally. This disruption can be buffered by the use of a coordinated and sustainable model for peripartum transfers, as developed by the Home Birth Summit (HBS 2014) in their Best Practice Guidelines for transfers of planned homebirths to hospital settings. This approach smooths inefficiencies,

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1 We alternate between the terms “patient” and “client” to describe the individual receiving maternity care, recognizing that “patient” more closely represents a role within the obstetric model of care and “client” more closely represents a role in the midwifery model of care.
2 We default to the term “mother” and she/her pronouns in describing people who receive maternity care. We note that not all pregnant persons identify as women or as mothers, and not all mothers gestate or give birth to their children. We discuss pregnant transgender and nonbinary individuals and gestational surrogates in the Further Considerations section.

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promotes optimal maternal and newborn outcomes, and best supports the needs and wishes of the mother, all while forging a sustainable system that conserves resources and recognizes the contributions of the transferring provider.

4.2 Transfers of Maternity Care: Who, When, Why, and to What End?

With a few exceptions, in the United States, the planned settings for birth include home, birth center (hospital-based or freestanding), or a hospital obstetric unit. Transfer of care may occur at any point during pregnancy, labor, or the immediate postpartum period; generally, this reflects a shift from a lower to a higher level of anticipated obstetric interventions. The protocols supporting these transfers and attitudes of providers involved deeply impact how smoothly the transfer proceeds for all parties.

Hospital transfers occur in approximately 9–13% of planned homebirths in the United States (Vedam et al. 2014). Transfers are more common for primiparas (23.4–45.4%; Blix et al. 2014), for subsequent births after cesarean (Cox et al. 2015), and for clients with preexisting conditions (Snowden et al. 2015). The most common indication for transfer is “failure to progress” (Blix et al. 2016; Cheyney et al. 2014a; Cox et al. 2015; Johnson and Daviss 2005), and only few transfers (0–5.4%) are due to obstetric emergencies (Blix et al. 2016). Even among women who plan a homebirth after cesarean (HBAC), the primary indication for transfer remains “failure to progress” (Rowe et al. 2015).

While a peripartum transfer does not preclude spontaneous vaginal birth, transfer can lead to instrumental or operative delivery. Rates of cesarean birth following transfer from homebirth settings in the United States ranged from 10.6% in primiparous women to 12.8% in women who attempted HBAC (Cox et al. 2015). Given the desire of those who plan out-of-hospital birth to avoid most obstetric interventions, the likelihood of instrumental or operative delivery may complicate or delay the decision to transfer for both providers and clients.

In addition to having an increased likelihood of obstetric interventions, transfers can be emotionally challenging. How might it be possible to better support the transferring client’s psychosocial and clinical needs, especially if “failure to progress” or desire for pharmacological pain management suggests the non-emergent nature of most peripartum transfers?

4.3 A Sustainable and Humanized Approach to Transfers of Care

We build upon Robbie Davis-Floyd’s (2018b) theoretical model for describing transfers of care in terms of disarticulation, fractured articulation, smooth articulation, and seamless articulation between homebirth midwives and hospital-based...
providers. Smooth articulation between providers is critical to mothers and midwives, and it can also influence decisions about transfers of care, as providers on both ends make future decisions based on past experiences (Johnson and Davis-Floyd 2006; Davis-Floyd 2018b; Cheyney et al. 2014b). Where can we find this smooth articulation and where do we not?

In the Netherlands, low-risk women routinely receive care from midwives and are transferred to secondary care directed by obstetricians if complications arise. Secondary care may also include care provided by clinical midwives, which is associated with decreased instrumental delivery (Wiegers and Hukkelhoven 2010, Bommarito, 2020). In determining whether a transfer should occur, the Dutch Obstetrical Indications List distinguishes between “physiological” and “pathological” birth—rather than between “low-risk” and “high-risk” as in the United States—and provides a framework for interprofessional collaboration (DeVries et al. 2009).

The United States has historically lacked a similarly cohesive and broadly accepted framework for transfers of care, although the Best Practice Guidelines (HBS 2014) seek to change that. The guidelines were based on the Smooth Transitions program, stemming from the work of the Midwives Alliance of Washington State (MAWS) to produce an evidence-based document that outlines the different indications for discussion, consultation, and transfer of care (MAWS 2016). In 2009, Smooth Transitions began reaching out to hospitals and asking them to voluntarily participate in the program, focusing on birthing sites where tensions between local community midwives and hospital staff appeared greatest. As part of the Smooth Transitions program, pairs of midwives and obstetricians visited hospitals and gathered information about liability, risk management, and the perspectives of the health care team, to better understand what went well and what went poorly during transfers. Smooth Transitions also educated healthcare professionals in the hospital setting, finding that staff often didn’t know that midwives were licensed in Washington, what training they had, or what equipment and medication they carried. Smooth Transitions recommended that hospitals set up a planning committee with licensed midwives that would address what would make transfers go most smoothly. Due to this initiative in Washington State, non-emergent transfers of care have become relatively smooth, while emergent transfers of care, particularly neonatal emergency transfers, could still use more support (Audrey Levine, personal communication).

The Best Practice Guidelines were developed by 11 delegates to the Home Birth Summits held in 2011 and 2013, including homebirth midwives, hospital providers and administrators, academic researchers, and advocates. The Best Practice Guidelines (HBS 2014) include 22 specified guidelines in three distinct categories: model practices for homebirth providers, model practices for hospital providers and staff, and quality improvement and policy development. The document emphasizes the importance of good communication between providers, a consideration of the transferring woman’s psychosocial needs, opportunities for continued involvement of the transferring provider and interprofessional collaboration, and ongoing opportunities to strengthen quality improvement and the development of policies and protocols. Thus far the guidelines have had a scattered reception, with a possible greater integration in the Northwest and less integration in the Northeast (Audrey Levine,
Judy Norsigian, and Kristen Leonard, personal communication). Part of this dynamic may be attributable to state-by-state differences in licensure, such that hospitals in states that do not formally recognize or license certified professional midwives (CPMs) would be unlikely to adopt the guidelines for reasons of liability (Judy Norsigian, personal communication).

We argue that the Best Practice Guidelines (HBS 2014), in conjunction with the related guidelines for interprofessional collaboration across the span of maternity care and the newborn period (HBS 2020), represent a sustainable framework for prenatal and peripartum transfers that may be particularly salient during times of disruption, such as during public health emergencies like the coronavirus pandemic. This approach is explicitly sustainable in that it embodies humanized birth, conserves resources, and provides a context for interprofessional collaboration and coordination of care. Humanized childbirth places the laboring woman at the center of her care and emphasizes that her experience and agency matter (McKay 1991; Wagner 2001, 2006, Davis-Floyd 2018a). A humanized approach to childbirth is sustainable, given its holistic focus on the pregnant individual’s physical, social, and emotional needs as well as its reliance on evidence-based care. Indeed, we argue that a paradigm for birth that does not work for the person giving birth—by failing to fully recognize her humanity or causing her distress or poor outcomes—will itself not be sustainable over time. The principles of transfers of care are sustainable if they lower the incidence of costly interventions while remaining flexible and adaptable to the needs of mothers and babies so that their outcomes and experiences are improved. Where healthcare systems face increased stress or resource scarcity, ways to integrate community-based providers, reduce distress, and avoid unnecessary delays may be all the more vital.

The need for clear communication between out-of-hospital providers and receiving clinicians neither begins with nor ends when care is transferred. The Best Practice Guidelines (HBS 2014) recognize this through advocating for “[o]pportunities for education regarding home birth practice, shared continuing medical education, and relationship building.” Midwives have voiced an unfulfilled need for post-transfer debriefing with hospital providers (Kuliukas et al. 2015) that might be further addressed via interprofessional working groups (Cheyney 2011; Bommarito 2020) and interprofessional education (Avery et al. 2012). Meeting this need would help acknowledge the important role played by community midwives and could positively impact decision-making about future potential transfers. This communication could further facilitate seamless articulation in peripartum transfers, wherein the transferring midwife remains with the client throughout her birth, working cooperatively with hospital providers.

Such coordination would further strengthen collaboration during transfers of care earlier in pregnancy (e.g., MAWS 2016). Many conditions considered to be higher risk can be safely monitored and managed by a homebirth midwife when

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3 Given limited published information about the implementation of the Best Practice Guidelines, we reached out to a small number of homebirth midwives and/or birth advocates, including several authors of the guidelines. Their insights are cited as personal communication.
there is collaboration with other providers, and having a multidirectional preexisting framework facilitates these prenatal transfers of care.

4.3.1 Maintain the Pregnant Client’s Support Personnel

The indication and timing of prenatal and peripartum transfers impact both clinical and psychosocial outcomes. In a transfer prior to the onset of labor, a pregnancy complication may necessitate an urgent labor induction, without the time to develop a new patient–provider relationship. Alternately, some prenatal transfers may allow more time to establish a new patient–provider relationship that can take the patient’s desires around birth into greater consideration.

When care is transferred after spontaneous onset of labor, whether due to “failure to progress” or obstetric complications, less time is available to develop a new patient–provider relationship. Hospital transfers may result in negative feelings about the birth experience (Geerts et al. 2014; Lindgren et al. 2011), which can increase the risk of postpartum depression (Bielinski-Blattmann et al. 2016). Such disarticulations in transfers can also leave midwives feeling invisible when their knowledge of the client is disregarded by the obstetric team (Davis-Floyd 2018b; Kuliukas et al. 2015). Maintaining continuity of the laboring woman’s support personnel not only improves maternal and newborn outcomes (Shaw et al. 2016) but also improves maternal comfort, which may result in fewer interventions. This is recognized throughout the Best Practice Guidelines (HBS 2014), including recommendations (1) that transferring providers may continue to serve as the primary birth attendant if doing so is within their scope of practice and if they have admitting privileges; (2) that hospital staff support the presence of the transferring providers in addition to the patient’s primary support person; and (3) that transferring and receiving providers coordinate in planning follow-up care, which may revert care for the postpartum woman to the transferring provider.

4.3.2 Avoid Unnecessary Replication of Tests and Procedures

Hospital births are generally more costly than out-of-hospital births (MacDorman et al. 2012; Boucher et al. 2009; Anderson et al. 2021), although out-of-pocket expenses may vary depending upon insurance coverage, local rates, interventions used, and the length of the hospital stay. While a peripartum transfer nearly always increases costs, the additional expense could be partially mediated by avoiding the unnecessary replication of tests and procedures already performed. Having accurate diagnostic information is important in clinically managing complications and ensuring that the receiving care team has access to all relevant information can reduce costs and increase efficiency. This is supported through the Best Practice Guidelines (HBS 2014) recommendations that the transferring midwife provide both a verbal
report to the receiving provider and a copy of the relevant prenatal and labor charts. This may be especially relevant in prenatal transfers, where diagnostics should focus upon addressing any complication that precipitated the transfer and routine procedures for the remainder of the pregnancy, rather than repeating tests that had already been administered by the transferring provider.

4.3.3 Limit Obstetric Interventions to Those Medically Indicated and Desired by the Pregnant Client

Clinical outcomes are qualitatively different when care is transferred, including increased rates of interventions and adverse outcomes (Laws et al. 2014). This disparity is inherently related to the indications for the transfer but may also be impacted by the transfer itself, including coordination of care or lack thereof. The Best Practice Guidelines recommend following “[a] defined process to regularly review transfers that includes all stakeholders with a shared goal of quality improvement and safety” (HBS 2014), which could further illuminate both areas where needed interventions are refused as well as ones where unnecessary interventions were made. Elective obstetric interventions increase the resources—instrumental, pharmacological, and financial—used for birth, without necessarily improving outcomes. While the use of medically necessary obstetric interventions may save lives or preserve function, their usage when not indicated increases costs and may result in poorer outcomes for mothers or neonates.

4.3.4 Eliminate the Fragmentation of Care Between Sites and Providers During Transfers of Care

Collaborative relationships between community-based and hospital-based providers could eliminate the fractured articulations or fragmentation of care that can lead to poorer outcomes (HBS 2020). The National Institute for Health and Care Excellence (NICE) recommends that collaboration between homebirth and hospital-based providers in the United Kingdom be initiated during prenatal care and provided in all low-risk pregnancies (Shaw et al. 2016). Within the United States, Declercq (2012) advocates for developing coordinated policies governing transfers and routes of communication between homebirth midwives and hospital staff, guided by professional organizations. This sentiment is echoed in the Best Practice Guidelines (HBS 2014), which include coordinated follow-up care for both the mother and neonate, as well as the potential for the homebirth provider to resume primary responsibility for care after discharge, as well as in the guidelines for interprofessional collaboration between community midwives and specialist providers (HBS 2020).
Preregistration of planned homebirths by the potential receiving hospital would result in swifter transfers while reducing last-minute replication of data entry or diagnostic tests (Blix et al. 2016). While registering and tracking the majority of planned homebirths that do occur at home would initially expend additional hospital resources, in the long term it could save hospital resources by reducing the hesitation that a provider or client would feel toward transfer, thus resulting in earlier transfers where indicated and potentially fewer operative deliveries. Significantly, the expanded dataset could be useful for research comparing home and hospital birth and thus could inform evidence-based childbirth practices, along with setting the framework for a regular review of transfers by all stakeholders specified in the Best Practice Guidelines (HBS 2014). Preregistration could further contribute to an easing of tensions between homebirth midwives and hospital-based providers, who often believe that homebirth is unsafe or are reluctant to assume responsibility for a homebirth transfer (Vedam et al. 2014; Davis-Floyd 2018b; Cheyney et al. 2014b; Declercq 2012).

Alternately, interprofessional collaboration can focus on future providers rather than existing practitioners, such as by incorporating interprofessional practice into academic programs in medicine, nursing, and midwifery (Vedam et al. 2014). This approach should emphasize system issues and support relationship-building between students and practitioners from different domains (HBS 2014). Exposure to a different knowledge base will give students a better understanding of one another’s scope of practice and will prepare medical students to collaborate with midwives and other healthcare professionals, potentially altering attitudes toward out-of-hospital births and resulting in more harmonious, smooth, or seamless future transfers.

As this chapter is heading to press, the global community is grappling with the COVID-19 pandemic that has upended daily life and imposed restrictions, including limitations on support persons and visitors for individuals planning hospital births (Davis-Floyd et al. 2020). Fears of giving birth in overwhelmed hospitals have led to surging interest in homebirth among currently pregnant individuals (Gammon 2020), even as midwives struggle to secure adequate personal protective equipment and face their own risks of infection (Candib et al. 2020). In this time of disruption, Candib et al. (2020) have called for Massachusetts homebirth providers to be included in emergency planning for maternity care during the COVID-19 crisis and licensed to provide services. This call is consonant with a recent recommendation on COVID-19 by the American College of Obstetricians and Gynecologists (2020) advocating innovative collaboration between hospitals and community-based providers. As transfer presents additional risks of infection and engagement with strained hospital systems, implementation of the Best Practice Guidelines (HBS 2020) to support greater involvement of homebirth midwives during this time of disruption would help increase safety while preparing to support the needs of the community into the future (Candib et al. 2020; Davis-Floyd et al. 2020).
4.4 Further Considerations

While enhancing sustainability in transfers of care is important for all patients, some populations face increased vulnerability. These populations may include, but are not limited to, survivors of abuse, immigrants, transgender or nonbinary individuals, or gestational surrogates. As such, we have addressed how promotion of a sustainable, humanized approach to transfers of care can support these populations.

Birth may be particularly triggering for survivors of sexual abuse, who face a 13-fold increase in risk of cesarean and tenfold increase of risk of instrumental delivery (Nerum et al. 2010). Transfer to an unfamiliar provider may exacerbate prior trauma, especially when a survivor of abuse may have no choice but to receive care from a provider of a different gender than anticipated. Because the receiving provider may be unaware of the patient’s history of sexual trauma, all providers should follow universal precautions (e.g., Coles and Jones 2009) by providing care that is trauma-informed and relevant to all patients, such as keeping the room temperature warm, asking before touching any body part, smiling and maintaining eye contact, or offering a same-sex provider (Gesink and Nattel 2015). Haen’s (2017) emphasis on supporting the agency of the survivor to make decisions about her own care, ideally with the continuous support of a doula, is fully compatible with sustainable transfers.

Immigrant women, who already face additional challenges in childbirth relative to their nonimmigrant peers (Barclay and Kent 1998; Van Roosmalen et al. 2003; Bakken et al. 2015), represent another vulnerable population in peripartum transfers. There may be difficulties in both linguistic and cultural translation, wherein the client may bring expectations that vary from the care that she receives, where she may be unable to articulate her wishes to a new care team and where she may not receive fully informed consent prior to the administration of obstetric procedures. Within the United States, undocumented immigrant women, who can be underinformed about options for out-of-hospital birth (Cadena 2013), may fear legal repercussions if a planned out-of-hospital or community birth is transferred to a hospital setting. Given the anti-immigrant tenor of the Trump administration (Lancet 2016) and ongoing efforts to deport undocumented persons, a humanized approach to peripartum transfers must protect against exposure of the patient or any family members to Immigration and Customs Enforcement. Further, a sustainable approach should mobilize existing hospital resources for linguistic translation en route and enable opportunities for cross-cultural communication about expectations for birth.

Relatively little has been written about the maternity care experiences of pregnant transgender men, who choose out-of-hospital birth at a much higher rate (22%; Light et al. 2014) than does the US population as a whole (1.36%; MacDorman et al. 2014). Transgender men who have given birth after socially and/or medically transitioning report that they desired more effective support resources and that care providers were unfamiliar with their needs (Light et al. 2014). Existing challenges faced by transgender and nonbinary gestational parents include being misgendered
by hospital staff and being reported to Child Protection Services (Light et al. 2014); these challenges may be exacerbated when care is transferred to new providers. A sustainable approach to transfers of care that creates pathways for seamless articulation between sending and receiving providers can help to minimize additional risks for pregnant transgender men and nonbinary individuals.

Unlike the other populations we have addressed, gestational surrogates may have limited choice in their own care due to the terms of the surrogacy contract or wishes of the commissioning parents, although the International Federation of Gynecology and Obstetrics (FIGO) emphasizes that the gestational surrogate maintains individual autonomy and that her wishes around childbirth should prevail (FIGO 2008; Söderström-Anttila et al. 2016). We do not know of any studies about homebirth among gestational surrogates, yet a humanized, sustainable approach to peripartum transfers in surrogate pregnancies necessitates an awareness of and sensitivity to the concerns of the gestational surrogate.

While increasing sustainability in transfers of care is an overarching goal, implementation must protect the most vulnerable populations. Additional resources—including staff who can devote time and sensitivity to addressing the needs of patients with diverse backgrounds and concerns—should be provided to fully meet the clinical and emotional needs of patients. This chapter has focused on transfers between sites of delivery rather than transfers within the hospital setting, but a recent retrospective cohort study in Ohio found that Black women were statistically more likely to transfer from midwifery to obstetric care both during prenatal care and peripartum (Weisband et al. 2018). Continued efforts to address enhancing sustainability in transfers of peripartum care must consider the role that race plays in maternity care and childbirth outcomes.

4.5 Conclusion

In improving the sustainability of peripartum transfers, our ability to make projections is only as strong as the available data and is thus hindered by systemic gaps in medical records. For instance, Lindgren et al. (2011) found that 15% of charts of homebirth transfers contained no information about the transferring provider. More effectively coordinated transfer of care, and better communication between providers working with different models of care—such as the obstetric versus midwifery models of care (Rothman 1982) or technocratic versus humanistic models of care (Davis-Floyd 1993, 2018a, c)—could lead to better data on transfers and ultimately improve transfers of care in the United States.

In the majority of cases, transfers of care involve an increase in obstetric interventions or technologies. However, these transfers can be made more seamless and sustainable by developing and implementing protocols and processes designed to support best practices (e.g., HBS 2014, 2020) and that make better use of available resources and supports, including the existing relationship between the transferring client and midwife. Simultaneously emphasizing sustainable and humanized
transfers of care will support the patients’ psychosocial and clinical needs while improving provider satisfaction. Furthermore, a coordinated system for review of these transfers can allow for continued quality improvement and opportunities for interprofessional collaboration and education (HBS 2014). While these changes will likely require adjustments to the operations of the receiving facility and within the belief systems of personnel involved in the transfer, they can ultimately pave the way to better outcomes for mothers and neonates.

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