



POSITION STATEMENT ON PLANNED HOME BIRTH IN NEW YORK

Women choose to birth at home for reasons of safety and quality of care.

Quality of care indicators such as support for physiologic birth, lower intervention rates, continuity of provider, and the ability to personalize care lead to high levels of satisfaction. These hallmarks of midwifery practice also enhance safety, and are among the primary reasons women choose to birth at home.

The safety of planned home birth with qualified midwives is supported by best evidence.

The best quality studies verify that planned home birth with legally qualified midwives results in excellent outcomes. Mothers experience lower rates of induction, epidural anesthesia, cesarean section, operative vaginal delivery, episiotomy and infection. Babies have lower incidence of prematurity, low birth weight, and resuscitation. Babies breastfeed longer and with less difficulty. Neonatal mortality rates for the newborns of healthy women are comparable between births in hospitals and births planned at home.

Women's right to choose planned home birth has overwhelming health policy support.

National maternal-child health organizations agree that quality home birth services should be available for women choosing home birth. Such organizations include, but are not limited to:

- American College of Nurse-Midwives (ACNM)
- Midwives Alliance of North America (MANA)
- American College of Obstetricians and Gynecologists (ACOG)
- Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)
- American Public Health Association (APHA)
- National Perinatal Association (NPA)
- Coalition for Improving Maternity Services (CIMS)
- Childbirth Connection

Midwives licensed by New York State are recognized as qualified planned home birth providers.

Midwives in New York State are licensed, independent, primary care providers as authorized by the Midwifery Practice Act of 1992. Midwifery scope of practice includes primary health care for women and newborns in hospital, birth center and home settings. New York State licensed midwives (LMs) have attained advanced degrees from nationally accredited midwifery programs that meet New York State educational standards. They take a licensing exam and are nationally certified. New York State law charges the Board of Midwifery with assuring the safety of the public through licensure, regulation, and discipline of midwives.

Midwives create a culture of safety by providing comprehensive maternity care.

Monitoring the well being of mother and baby throughout the childbearing cycle is integral to midwifery care. The mother receives comprehensive prenatal care, as well as hands-on support and monitoring during active labor. Care is focused on evidence-based support for physiologic birth with use of interventions only when clinically indicated.



Midwives facilitate quality care by engaging in a shared decision-making process with clients.

A pregnant woman's right to bodily integrity and self-determination is intrinsic to the midwifery and medical professions and is a foundational principle of organizations responsible for promoting quality maternity care. Shared decision-making grows out of the ethical principle of autonomy. Evidence suggests that greater patient involvement in care results in better health outcomes and higher levels of patient satisfaction. Midwives engage women and families in shared decision-making to promote individualization of care. Likewise, licensed midwives determine their professional competencies and boundaries within their scope of practice. Professional midwifery practice and women's desires are typically aligned. Therefore, a midwife honors the decision of a woman in her care as long as the following conditions are met:

- The midwife and the mother engage in a thorough process of shared decision-making. Clients typically sign forms documenting the education, decision-making, and informed consent process.
- The decision does not require the midwife to break the law or to compromise her own personal or professional integrity, which would put her in a position of negligence.
- The mother demonstrates competence and willingness to accept responsibility for the potential risks and results of her decision.

Midwives use ongoing screening to promote healthy outcomes for mothers and babies.

The midwife exercises clinical judgment in the selection of candidates most likely to experience healthy outcomes when planning childbirth at home. The best candidates are women who are essentially healthy with a full term singleton fetus in vertex presentation. These women and their partners also demonstrate the knowledge, capacity, and judgment to choose home birth and to adapt to the changeable nature of pregnancy, labor, and birth for both mother and newborn. In the case of complications, model midwifery practice utilizes consultation, collaboration, or referral according to the midwife's clinical practice guidelines.

Midwives have collaborative relationships with medical providers and transport to hospitals when specialized care is indicated.

The evidence for quality planned home birth services highlights the responsibility of the LM and local obstetrical system to coordinate communication and transfer of care to achieve optimal outcomes. As primary care providers, midwives provide on-going screening for women and babies in their care. When conditions arise that warrant specialized medical care, midwives facilitate the appropriate consultation, collaboration, or referral.

- Consultation occurs when the midwife seeks the opinion of a physician, or another member of the health care team. It may be a discussion by phone or in person, and may include a face-to-face visit between the client and consultant. The midwife maintains primary responsibility for the mother and newborn's care.
- Collaboration occurs when the midwife and physician, or another member of the health care team, jointly provide complex clinical care for a woman or newborn. Effective ongoing communication between the midwife and physician is essential for defining respective roles and responsibilities.
- Referral occurs when the midwife directs the mother or newborn to a physician, or another member of the health care team, for management of a particular aspect of care.

A small percentage of planned home births require transport to a hospital during the intrapartum period. Transports deemed to be urgent are made to the nearest, most appropriate hospital. Non-urgent transports are made to the hospital chosen by the woman and the midwife as part of their prenatal planning. See page 4, "NYSALM Model Practices for Planned Home Birth to Hospital Referral and Transport" for more details on this coordinated process.



References:

American College of Nurse Midwives (ACNM). Online at www.midwife.org. ACNM maintains position and policy statements, resources, and a bibliography for planned home birth including:

- Joint Statement on Practice Relations Between Ob-Gyns and CNM/CMs (2011)
- ACNM Core Competencies for Basic Midwifery Practice (2008)
- ACNM Standards for the Practice of Midwifery (2009)
- ACNM Code of Ethics (2008)
- ACNM Position Statement on Home Birth (2005)
- ACNM Position Statement on Creating a Culture of Safety in Midwifery Care (2006)

American College of Obstetricians and Gynecologists (ACOG). *Planned Home Birth* (Committee Opinion), 2011.

American Public Health Association (APHA). *Increasing Access to Out-of-Hospital Maternity Care Services through State-Regulated and Nationally-Certified Direct-Entry Midwives* (Policy Statement), 2001.

Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). *Midwifery* (Position Statement), 2009.

Coalition for Improving Maternity Care Services (CIMS). *The Mother-Friendly Childbirth Initiative*, 1996.

Downe, S, et al. *Creating a Collaborative Culture in Maternity Care*. *JMWH* 55(3) 250-254, 2010.

Jolivet, R, et al (Childbirth Connection). *Transforming Maternity Care - 2020 Vision for a High Quality, High Value Maternity Care System, and Blueprint for Action*, 2010.

Midwives Alliance of North America (MANA). *Statement of Values and Ethics*, 2010

Midwives Association of Washington State (MAWS). *Shared Decision-Making* (Position Statement), 2008.

National Perinatal Association, (NPA). *Choice of Birth Setting* (Position Paper), 2008.

New York State Education Department. *Midwifery*. Online: www.op.nysed.gov/prof/midwife

Sakala C, Corry M. *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. NY, NY: Milbank Memorial Fund. 2008.

Model Practices for Planned Home Birth to Hospital Referral and Transport

Background and Rationale

Midwives in New York practice as licensed, independent, primary care providers for women and newborns as authorized by the Midwifery Practice Act of 1992. Midwives provide maternity care in hospital, birth center, and home settings. As primary care providers, midwives consult, collaborate, and refer to other healthcare providers when women or newborns need specialized care. The Midwifery Modernization Act of 2010 removed the requirement for a written practice agreement, reinforcing collaborative relationships as the model for inter-professional coordination. For midwives who attend planned home births, these relationships are with hospitals offering obstetrical coverage, as well as specific obstetric providers. This ensures around the clock coverage for home to hospital referral and transfer.

New York State Association of Licensed Midwives (NYSALM) recommends the following model practices to midwives, physicians, hospitals, and hospital employees to make the transition to the hospital smooth, efficient, and safe. Coordination improves safety and is supported by evidence. Clear respectful communication is optimal for ensuring safe, high-quality care, and for promoting professional respect and patient satisfaction. Mutual attention to the transfer process includes the following recommendations:

Model practices for the midwife

- In the prenatal period, the midwife provides education to the mother about hospital interventions that are occasionally necessary and documents a plan with every woman for hospital transfer and referral.
- If a transport becomes necessary, the midwife notifies the receiving hospital of the incoming transfer, reason for referral, brief background clinical information, planned mode of transport, and expected time of arrival.
- Upon arrival at the hospital, the midwife provides a detailed oral report, including assessment and any urgent care needs, and transfers responsibility to the hospital provider. Midwives with admitting privileges at the receiving hospital may continue in the role of primary care provider.
- The midwife provides a copy or makes available pertinent prenatal and labor medical records.
- To the extent possible, the midwife facilitates both the woman's understanding of the hospital provider's new plan of care and the hospital provider's understanding of the woman's need for detailed information regarding care options.
- The midwife remains with the woman in the hospital to provide continuity.

Model practices for the hospital provider and hospital

- Hospital providers recognize the midwife as the mother and baby's primary care provider who has pertinent case information regarding the need for obstetric or neonatal care.
- The woman is admitted directly to Labor and Delivery, bypassing triage in the Emergency Department.
- The hospital staff integrates necessary interventions with the woman and family's preferences, giving attention to principles of shared decision-making and informed consent.
- The midwife accompanies the woman throughout procedures.
- The hospital provider and the midwife coordinate follow up care for the mother and baby. If within midwifery scope of practice, care reverts to the midwife upon discharge.
- Upon request, relevant medical records are sent to the referring midwife.
- When hospital case reviews are conducted, the midwife is included with the primary goal of collegial dialogue and mutual feedback to enhance safety and seamless coordination of care.

Physicians and midwives have a long history of working together for the improvement of maternal and child health. The best available evidence and public health policy recommendations support planned home birth as a reasonable option for women and families who seek a normal physiologic birth. The best available evidence shows that the highest quality of care occurs with inter-professional coordination across care settings.