Smooth Transitions

Making Hospital Transfers Better

by Aspen Green and Natalie Martina

Women in America have a vast array of options for childbirth. Many women and their families choose to give birth at home or in a birth center. In the United States in 2012, approximately 53,635 births (1.36%) occurred in a setting other than a hospital, and recently this number has been steadily increasing (MacDorman et al. 2014).

While planned birth outside of a hospital is generally accepted as a safe alternative to hospital birth, at times transfer to the hospital becomes necessary. A recent review of the literature found that the rate of transfers from birth centers was between 11.6 and 37.4% (Alliman and Phillippi 2016). Data analysis by the Midwives Alliance of North America (MANA) Statistics Project determined that almost 11% of women needed the additional care of a hospital (Cheyney et al. 2014). Fortunately, most hospital transfers are for non-emergency reasons, such as failure to progress or pain relief.

When the need for hospital transfer arises, it is important to have a plan and open communication. The safety of birth in the home or at a birth center when problems arise relies on integrated maternity care systems where midwives can develop collaborative relationships with hospitals and their care providers. As hospitalist nurse-midwives who assume the care of women transferring from a home or birth center to our hospitals, we would like to share some of our thoughts on how we can all contribute to making this transition as smooth as possible for all involved, especially the mother.

What hospital providers can do:

• Obstetric units should develop written plans for managing homebirth or birth center transfer patients. This assures that all staff can develop standard behaviors and communication skills when caring for these patients.
• Consider adopting best practice guidelines, such as those proposed by the Home Birth Summit in 2014, homebirthsummit.org/wp-content/uploads/2014/03/HomeBirthSummit_BestPracticeTransferGuidelines.pdf. The goal of these guidelines is to promote respectful, interprofessional collaboration; ongoing communication; and compassionate, family-centered care.
• Consider developing a perinatal collaborative for your community. In the San Francisco Bay Area, we started Birth Bridges, birthbridges.org, to create professional relationships that encourage mutual respect and open communication within our birth community.
• Consider biases that may arise from your own feelings or beliefs about homebirth and birth center birth. Be mindful of passing judgment on or mistreating the mother or her birth team. The goal is to take the best care of the patient possible.
• Be respectful toward the laboring mother. Recognize that women in labor, especially those who had wanted to birth at home or in a birth center, may take longer to process information. They may be scared, in pain, and, likely, disappointed that their original plan didn’t work out. Be as understanding as possible.
• Assign hospital staff who are supportive of homebirth—such as a certified nurse-midwife or a certified midwife. Minimize interventions that aren’t necessary and include the mom, her family, and her birth team in all decisions and discussions. Realize that a more lengthy conversation may be required when providing informed consent.
• Ensure that the environment is welcoming, and assure the mom that her wishes will be respected in the hospital. Be willing to openly discuss her birth preferences and share the decision-making to bridge the gaps. Remember that this is one of the most important experiences of her life and she will remember the way she was treated more than most of the details.

What home- or birth center-based providers can do:

• Look to professional literature regarding who may be a good candidate to attempt a home- or birth center birth. Inform pregnant women inquiring about out-of-hospital birth about general risk factors, especially those that may apply to them.
• Encourage your clients to steer clear of “hospital-bashing” media, such as anti-medicine or anti-doctor blogs. Help them cultivate trust and tune out fear. Educate them about hospital protocols and procedures and the professional recommendations from which these are often derived. Help them to understand that the hospital and its providers are part of the birth team when needed.
• Prepare a plan in case the mom has to transfer to a hospital. Speak openly with
your clients ahead of time about scenarios that might require transfer and what options could be presented to her. Ask your clients if they would like to attend a hospital tour during their pregnancy. Feel free to come along with them or ask if they would like to invite their doula.

- If it becomes evident that a transport to the hospital is necessary, don’t wait. This scenario is, of course, no one’s fault and sometimes can’t be avoided. Try to call the hospital ahead of time and give them notification that you are coming so that they can make sure they are prepared.

- Once at the hospital, try to be unified with the on-call providers when interventions are recommended. Assisting the woman to engage in discussions about risk, benefits, and alternatives to interventions allows the team to build trust.

- Bring in all prenatal records, including the labor record. Don’t try to hide information for fear of being judged or punished.

- If at all possible, stay with your client. She knows you and you have been allowed time to gain her trust. She looks to you for support and advice when weighing decisions she is facing.

Finally, let’s acknowledge that our roles are different—but neither is less valuable than the other. Only together are we are able to provide women with the options they seek to give birth where and with whom they feel comfortable. Hospital, birth center, or home—we, as midwives are “with women.”

We all know that no one can truly plan a birth, but we can plan for a smooth transition from a home or birth center to a hospital setting. We’re confident that we can continue to make this process better for all involved.

**References:**


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