

Swedish First Hill – Transfer Guideline from Planned Community Birth:

Neonatal

Swedish First Hill welcomes patients who are transferred from a planned community birth. We work with the local community midwives needing our services to provide a smooth transfer of care in order to optimize outcomes and experiences for our shared patients. The hospital team recognizes that the hospital is not the patient's preferred site for delivery, postpartum, or neonatal care. Our staff will strive to acknowledge this and convey our understanding directly to the patient, while providing them with high quality and compassionate care.

Community midwives might consider encouraging their clients to:

- Take a virtual tour of the hospital by visiting:
<https://www.swedish.org/services/pregnancy-and-childbirth/classes-and-tours/birth-center-tours>
- Draft a birth plan in the event of hospital transfer

Note: We at Swedish FH are prepared to accept any newborn infant and their birth parent as needed after an unexpected complication during a community birth. If arriving by EMS, we will typically receive prehospital notification as well as bedside handoff, at minimum. Prearrival notification from the community midwife is always appreciated, as it can help us gather the appropriate teams and resources, but we understand that the focus should be on caring for the infant and the birth parent.

Transfer of a neonate:

1. If emergent, community midwife calls **911** to request transfer/transport.
2. If possible, community midwife calls the **First Hill ED at 206-386-2573** and asks to give report to an emergency attending. The community midwife, if possible, will accompany their client. If unable to accompany client, a practitioner-to-practitioner phone call (when time and situation allows) is strongly recommended.
3. The newborn will arrive through the **main ED**
4. The community midwife will provide relevant medical records either before arrival or at the time of transfer which will be placed in the patient's chart. Records may be faxed or brought in and photocopied/scanned.
 - a. **First Hill ED Fax: 206-386-2577**
 - b. If newborn is admitted to the **NICU**, the community midwife may need to communicate with the receiving provider(s) by phone: **NICU: 206-386-2430**
5. The hospital care team recognizes the community midwife as the patient's primary care practitioner who has an established relationship with the patient. We encourage the community midwife (if present) to join with the hospital care team to provide ongoing support of the patient (and newborn's parent). If the community midwife leaves the hospital and the hospital care team has questions or needs clarification, they will reach out to the community midwife. See *Community Midwife Directory*.

Note: In the event of a transfer of a newborn wherein the birth person is also present and has not been evaluated thoroughly by the transferring community midwife, coordination by the ED providers and staff may take place with the community midwife and family to provide for appropriate care for the birth person as needed.

6. The hospital care team (i.e., pediatric hospitalist) will coordinate with the community midwife a schedule of follow-up care for the newborn. (See below for information regarding the postpartum and newborn scope of practice for Licensed Midwives in Washington State)
7. The discharging care team will request that relevant hospital records are sent to the community

midwife, so they are available for review prior to follow-up with the patient.

8. Everyone's feedback is encouraged through the Smooth Transition® surveys and data collection tools. There are surveys for the **receiving provider, nursing, community midwife, client, doula, and EMS providers**. The data from these surveys are de-identified, aggregated into a report and reviewed quarterly. See posters for QR code or visit:

<https://www.qualityhealth.org/smoothtransitions/surveys-2/>

If the transfer of care to Swedish First Hill fell below expectations, we ask that follow-up be provided with the appropriate contacts so that direct, immediate feedback may be shared with respective care teams.

Please direct feedback to:

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Med Director, ED

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Andrew Beckstrom, Neonatologist

NICU Med Director

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Below are resources containing information and education regarding community midwives in WA State, their scope of practice, training, and guidance provided by midwifery professional associations.

**WA State Licensed Midwifery Scope of Care & Routine Care:**  
**Gestational Parent & Newborn**

**Washington Licensed Midwives (ed 4/22/25)**

**Scope of Practice**

WA Licensed Midwives (LMs) are regulated by the Washington State Department of Health. They are licensed to provide prenatal, intrapartum, postpartum and newborn care and are tasked with consulting with a physician whenever there are significant deviations from normal in either the parent or the newborn per [RCW 18.50.010](#). Midwives who practice in birth centers have additional restrictions based on requirements of licensed birth centers in [RCW 18.46](#). Licensed birth center only deliver singleton cephalic term babies. Elements of newborn care can be found in [WAC 246-834-255](#)

[RCW 18.50.108](#) requires LMs to develop a written plan for consultation with other health care providers, emergency transfer, transport of an infant to a newborn nursery or neonatal intensive care nursery, and transport of an individual to an appropriate obstetrical department or patient care area. The written plan must be submitted annually together with the license renewal fee to the Department of Health.

[RCW 18.50.115](#) allows for LMs to obtain three separate license extensions that can be used to increase their scope of care. With these extensions, midwives can prescribe medications for the prevention or treatment of common perinatal conditions, insert and remove IUDs, and insert and remove implantable contraception.

## **Training Requirements**

WA LMs are required by [RCW 18.50.040](#) to train for at least three years and include both didactic work and clinical rotations. Didactic work includes the study of: obstetrics; neonatal pediatrics; basic sciences; female reproductive anatomy and physiology; behavioral sciences; childbirth education; community care; obstetrical pharmacology; epidemiology; gynecology; family planning; genetics; embryology; neonatology; the medical and legal aspects of midwifery; nutrition during pregnancy and lactation; breastfeeding and nursing skills (including injections, IV administration, catheterization, and aseptic technique). Clinical requires at least two sites that are focused on birth center or home birth where students learn all aspects of care and they must have participated in at least 100 deliveries before being eligible for Washington licensing.

Bastyr University Department of Midwifery offers a Masters of Science in Midwifery degree. More than half of the LMs in WA have graduated from this program since 2010 or from its predecessor, the Seattle Midwifery School, founded in 1978. The remaining LMs in the state have completed their education through one of several accredited distance learning programs, including the Midwives College of Utah and the National College of Midwifery. A majority of the LMs in WA, having completed the North American Registry of Midwives exam, also hold the national credential of Certified Professional Midwife (CPM).

## **Legend Drugs and Devices**

According to [WAC 246-834-250](#) licensed midwives can:

- Draw blood and collect appropriate samples for lab testing (for example routine bloodwork, paps, bilirubin, newborn screening samples)
- Administer appropriate vaccinations during pregnancy and in the newborn period.
- Administer Rho(D) immune globulin as appropriate
- Administer IVs (for hydration, antibiotics during labor, and hemorrhage treatment).
- Perform limited OB ultrasound and refer out to radiology or MFM for more detailed ultrasounds. They can perform NSTs.
- Suture routine lacerations after delivery (including appropriate anesthetics)
- Monitor fetuses using NSTs in the antepartum period (though they do not provide continuous fetal monitoring during labor)
- Perform urinary catheterization
- Utilize drugs and devices to manage hemorrhage (for example: antihemorrhagics like pitocin, misoprostol and methergine, TXA, Jada)
- Perform neonatal resuscitation including use of oxygen, masks, pulse ox, LMAs, and cpap, and UVC or IO epinephrine
- Prescribe glucometers for managing blood sugar during pregnancy, and do asses glucose values in the gestational parent or newborn
- Administer nitrous oxide for analgesia during labor and other procedures

- Prescribe and administer multiple types of birth control (including hormonal and non-hormonal, IUDs, and implants)
- Perform hearing screens on infants
- Prescribe medications for common perinatal conditions (for example: anti-emetics, antibiotics, antifungals, stool softeners, prenatal vitamins, hormonal and non-hormonal birth control, and others)

### **Routine Care Provided by Licensed Midwives to in the Prenatal Period**

- 7-15 prenatal visits throughout pregnancy
- Initial history taking, physical exam, and discussion of all screening tests offered for both gestational parent and fetal health
- Screening and diagnostic bloodwork, as appropriate
- Vaccinations and Rho(D) immune globulin, as appropriate
- Ultrasounds and NSTs as appropriate, done onsite or through referral
- Medications prescribed as necessary for common perinatal conditions, avoiding additional unnecessary visits to a primary care doctor
- Continual assessment of appropriateness of community birth or referral for in-hospital delivery

### **Routine Care Provided by Licensed Midwives during Labor**

- Labor and delivery care for babies at term. Licensed midwives can deliver breech and twins, but birth center based practices do not
- Can provide GBS prophylaxis, IV fluids PRN
- Intermittent fetal monitoring (shown to be adequate for low-risk pregnancies)
- Nitrous oxide for pain relief
- No pharmacologic induction of labor or augmentation
- No epidurals
- No forceps or vacuum deliveries
- Facilitation to hospital care when necessary (for example: prolonged labor, patient request for pain relief, postpartum hemorrhage, need for care not available in the community – like augmentation, surgery, forceps, or vacuum). This includes providing necessary records, giving report to the receiving provider, and coming to the hospital for a handoff.

### **Routine Care Provided by Licensed Midwives to Gestational Parents and Newborns ([WAC 246-834-255](#)) in the 24 Hour Postpartum Period**

- Active management
- Initial postpartum hemorrhage management (transfer to hospital if appropriate)
- Initial newborn resuscitation (transfer to hospital if appropriate)
- IV fluids PRN
- Suturing of 1<sup>st</sup> and 2<sup>nd</sup> degree lacerations
- Lactation support
- Full newborn exam with tongue tie assessment
- Newborn procedures can include vitamin K, erythromycin, hepatitis B vaccine, glucose levels, pulse oximetry, blood typing, hearing screen
- Discharge at 3-5 hours post delivery with planned in-home follow up the next day

- Home visit with newborn metabolic screen, CCHD, weight check and jaundice/bilirubin screen for baby
- Home visit with physical exam, lactation assistance, and Rho(D) immunoglobulin administration as appropriate

### **Routine Care Provided by Licensed Midwives to Gestational Parents and Newborns in the *Postpartum Period***

- Two weeks of care for newborn patients, including lactation help, weight checks, 2<sup>nd</sup> metabolic screen, jaundice/bilirubin screening, and referral to a pediatrician for ongoing care
- Six weeks of care for parent, lactation support, screening for postpartum mood disorders, cervical cancer screening, family planning counseling, and referral for ongoing care
- Referral to the hospital for complications including postpartum pre-eclampsia, jaundice requiring treatment, or other conditions requiring a higher level of care.
- The HCA has defined the “postpartum period” as twelve months after delivery, so some midwives may continue seeing the gestational parent for normal postpartum care. This may include blood draws to check on recovery from childbirth, BP checks to assess for normotensive status, family planning services, and continuing screening for postpartum mood disorders.

Licensed Midwives refer the well newborn to begin pediatric care between two and four weeks of age. If at any time the midwife has concern(s) about the well-being of the newborn, that falls outside of the Licensed Midwife’s scope of practice, they would be referred to pediatric care at that time. Communication and discussion across the care team are essential to providing appropriate, safe, and satisfactory care for families.

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[Midwives’ Association of Washington State \(MAWS\): MAWS Indications for Discussion, Consultation, and Transfer of Care In a Community Based Midwifery Practice](#)

[Washington Alliance for Responsible Midwifery \(WARM\): Considerations for Care, Consultation and Referral](#)