Swedish First Hill – Transfer Guideline from Planned Community Birth: Gestational Parent

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: A phone call from the community midwife to the hospital team is to promote care coordination and optimize the patient's care experience. Swedish First Hill has an OBED that is always open and available to provide care—the community midwife does not have to get permission in order to refer a patient for assessment.

Emergent Transfer – Intrapartum or Immediate Postpartum:

1. Community midwife calls **911** to request transfer/transport
2. If possible, community midwife calls **206-215-3706** to speak to the Charge Nurse to give a brief report and ETA. 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 client will arrive through the **OB 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. **5 East Fax: 206-215-3455**

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

Non-Emergent Transfer – Intrapartum or Immediate Postpartum:

1. The community midwife calls the L&D charge nurse to inquire about space and staffing by calling **206-215-3706**
    a. The community midwife will request to speak with the on-call OB hospitalist or on-call CNM, based on patient acuity.
    b. Community midwife indicates if the patient has Kaiser insurance so they may be assessed and cared for by the Kaiser OB/GYN group.

    Note: The SMG CNM is backed up by the SMG OBGYN rather than the OB hospitalist (see below for community midwife → CNM transfer criteria).

    c. The community midwife's report to the receiving OB or CNM will include the client's name, age, G/P and DOB, reason for transfer, relevant clinical background information, their current condition, the planned mode of transfer, and the expected time of arrival.

2. The receiving OB or CNM will then convey this information to the L&D charge nurse who will facilitate a direct admission so that the patient can be brought to a labor room upon arrival.
3. 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. **5 East Fax: 206-215-3455**
4. If possible, the community midwife will accompany their client to the hospital to facilitate a warm **handoff** of care. At the hospital, **prior to initiating care,** the hospital care team (i.e., receiving OB or CNM, bedside nurse) will gather at the bedside of the client with the community midwife and the client's doula and/or support team for introductions. The group will then discuss the patient's care, plan of action, and answer questions.
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 to join with the hospital care team to provide ongoing support and care of the patient. 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.
6. The hospital care team (i.e., OB hospitalist, CNM, pediatric hospitalist) will coordinate with the community midwife a schedule of follow-up care for the patient and/or 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 to the nursing and practitioner leadership ASAP so that we can provide direct, immediate feedback to our care team.

Please direct feedback to:

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Johanna.Estes@Swedish.org

Katherine Eastwood, MD
Medical Director OB Quality and Safety
Katherine.Eastwood@Swedish.org

Smooth Transitions Program Manager
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Community Midwife → CNM transfer

In these cases, the Swedish CNMs will be backed up by the Swedish OB/GYN group.

Indications for transfer that can be managed by CNM
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1. Epidural and/or pain management
2. Pitocin augmentation of labor
3. Meconium-stained amniotic fluid
4. Medically indicated induction (for indications within CNM scope of practice)

Criteria for acceptance of transfer from community midwife to CNM

1. Established dates, gestation 35+0 weeks or greater
2. Preterm labor management ≥35+0 weeks
3. Adequate prenatal care, including GDM screening and anatomy scan ultrasound
4. Reassuring fetal status at time of transfer
5. Suspected normal EFW
6. Vertex presentation
7. No signs of chorioamnionitis
8. No prolonged 2nd stage
9. No previous cesarean

Community midwife → OB Hospitalist transfer

For any patients not meeting the above criteria, the community midwife should coordinate transfer with the OB Hospitalist. The OB Hospitalist will do the initial assessment of the patient. On a case-by-case basis, a patient could be transferred to CNM care if agreed to by the OB Hospitalist, the CNM and the patient. *In these cases, the CNMs will be backed up by the OB Hospitalist for this patient's care.*

Note: If a patient transferring to Swedish First Hill has Kaiser insurance, they should be cared for by the Kaiser OB/GYN group.

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Urgent Antepartum Evaluation in OBED

For **prompt assessment in the OB ED**:

1. The community midwife calls the L&D charge nurse to give notification that the patient will be arriving in the **OB ED**. **206-215-3706**
    a. The community midwife will request to speak with the on-call OB hospitalist or on-call CNM, based on patient acuity, to give report.
    b. Community midwife indicates if the patient has Kaiser insurance so they may be assessed and cared for by the Kaiser OB/GYN group.
    c. The community midwife's report to the receiving OB or CNM will include the client's name, age, G/P and DOB, reason for transfer, relevant clinical background information, their current condition, the planned mode of transfer, and the expected time of arrival.
2. The community midwife will provide relevant medical records, which will be placed in the patient's chart. **5 East Fax: 206-215-3455**

Note: A phone call from a community midwife to the hospital team is to promote care coordination and coordinate the patient's care experience. Swedish First Hill has an OBED that is always open and available to provide care—a community midwife is not calling to request permission to refer a patient for assessment.

Outpatient transfer of care:
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1. The patient is welcome to call the clinic directly to schedule an appointment: the front desk will schedule the next available appointment and ask the patient to sign an ROI to request their prenatal records; if the timeline for the appointment is satisfactory to the patient/community midwife, then nothing else needs to be done.
2. If the situation is complex or a very prompt appointment is needed, the community midwife is encouraged to call clinic to coordinate care:
    - For the First Hill OB/GYN and Midwifery clinic, call **206-215-6900** and **choose 3** (option for 'if you are a provider…') to either speak with a CNM/MD (if available) or to leave a message that will be sent to the provider in-basket, and they will return the call.
3. The community midwife should fax records: First Hill office fax is **206-215-6301.**
4. The CNM or MD may request to review prenatal records before deciding about accepting care, depending on the gestational age and the reason for transfer.
5. Note: Swedish has a variety of OB/GYN and Midwifery clinics in the Seattle area. Patients do not need to transfer to the First Hill practice specifically.

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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.
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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 metherine, TXA, jada)
- Perform neonatal resuscitation including using 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 1st and 2nd 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, 2nd 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
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