FAMILY MEDICINE LEADS
American Academy of Family Physicians Foundation

Home and Out-of-Hospital Birth in Texas

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AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION

Disclosures

- I have no financial disclosures
- I created and maintain TexasHomeBirth.com

SAINT LOUIS UNIVERSITY
DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE

375th MEDICAL GROUP

Learning Objectives

1. Understand the current state of Out-of-hospital birth practice and regulation in Texas
2. Be able to discuss key information about regulation, safety, and standards of care
3. Become equipped with tools to help patients navigate this challenging issue

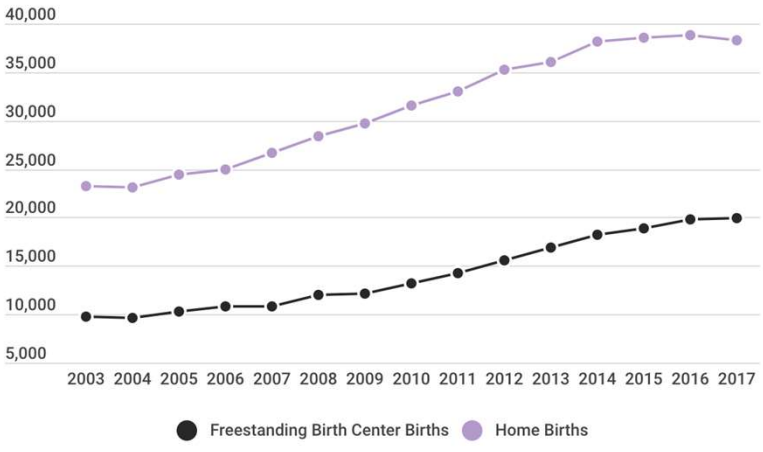
Your Stories

My Story

My Story

My Story

Out-of-hospital births are on the rise



Source: Gatehouse Media analyzed data from the CDC's Natality Files to determine the growth rate of births at home and in freestanding birth centers.

The State of Out of Hospital Birth

- Growing in popularity, 1.4% of Texas births
- Unregulated in many states
- Limited oversight
- Extremely polarizing
- Limited unbiased information for patients
- US versus Europe

PROVIDERS

Legal

- Physicians
- Certified Nurse Midwives
- Licensed Midwives
  - Usually Certified Professional Midwives

Not Legal

- Traditional Midwives/Parteras
- Certified Midwives

Texas Birth Attendant Comparison

Education and Training

EDUCATION/ TRAINING	PHYSICIAN	CERTIFIED NURSE MIDWIFE	LICENSED MIDWIFE
High School	✓	✓	✓
College	4 year degree + prerequisites	4 year Bachelor of Science in Nursing	Not required
Graduate School	4 years at accredited medical school	1-2 years accredited Master of Science in Nursing*	Not required
Postgraduate Training	3+ years accredited residency training	2 years accredited midwifery training	Not required

PROVIDERS

Certification Exam	ABMS, AOA, or ABPS Board Certification Exam in Obstetrics and Gynecology or Family Medicine	American Midwifery Certification Board Exam	Not Required
Licensure Exam	US Medical Licensing Exam (USMLE) or Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA)	National Council Licensure Exam for Nurses (NCLEX-RN)	North American Registry of Midwives (NARM) National Exam

PROVIDERS

Minimum Number of Primary Deliveries for Certification	OB/Gyn: 200 vaginal, 145 cesarean Family Medicine: 0 FM+OB Fellowship: 100 vaginal, 50 cesarean	No minimum requirement Competency must be verified by training program director	25 vaginal

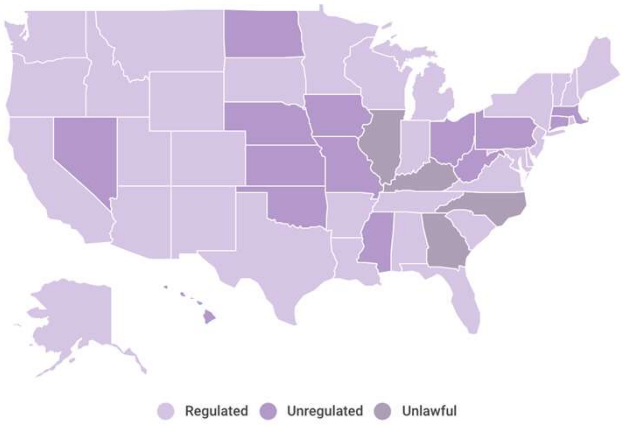
CPMs certified before 2013 were not required to have high school diploma or equivalent

CNMs certified before 2011 required BSN, active nursing license, and midwifery program (but no graduate degree)

As of 2017, ACGME has no minimum delivery requirements for family medicine residencies. Individual hospitals decide whether or not to award OB privileges to a family physician based on training and proven competency.

Non-nurse midwife legal status by state

Click on a state to see legal status



Source: Gatehouse Media

http://gatehousenews.com/failuretodeliver/explore-the-database/#states

CPM Training

Option 1: Apprentice with a qualified midwife, completing an Entry-Level Portfolio Evaluation Process (PEP)

- observe ten births,
- assist at 20 births
- attend 20 births as primary midwife (under supervision). The teaching midwife must have three years experience as a CPM or have attended 70

CPM Training

Option 2: Attend a midwifery program or school

- If the school is accredited by the Midwifery Education Accreditation Council, graduation qualifies a midwife for the NARM written exam
- If the school or program is not MEAC accredited, the applicant must complete the Entry-Level Portfolio Evaluation Process
- Texas Schools

CPM Training

Option 3: Obtain a license from their state first, and then apply for certification from NARM.

- applies if the aspiring midwife's licensing state has met "educational equivalency" requirements set by NARM.
- must also report ten births as primary midwife in the last three years. They are then awarded the CPM credential.

Global Standards

International Confederation of Midwives

Global Standards

Two-thirds of American CPMs are trained in self-study and apprenticeship programs or are certified after state licensure, and do not meet ICM global standards for midwifery education and training

ACOG Policy Statement

EVIDENCE

- Quality of studies
- MANA Stats 2004 - 2009
- Grunebaum, et al 2009
- GateHouse Media – Failure to Deliver

Journal of Midwifery & Women's Health www.jmwh.org
Original Research

Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009

Melissa Cheyney, PhD, CPM, LDM, Marit Bovbjerg, PhD, MS, Courtney Everson, MA, Wendy Gordon, MPH, CPM, LM, Darcy Hannibal, PhD, Saraswathi Vedam, CNM, MSN, RM

Introduction: Between 2004 and 2010, the number of home births in the United States rose by 41%, increasing the need for accurate assessment of the safety of planned home birth. This study examines outcomes of planned home births in the United States between 2004 and 2009.

Methods: We calculated descriptive statistics for maternal demographics, antenatal risk profiles, procedures, and outcomes of planned home births in the Midwives Alliance of North American Statistics Project (MANA Stats) 2.0 data registry. Data were analyzed according to intended and actual place of birth.

Results: Among 16,924 women who planned home births at the onset of labor, 89.1% gave birth at home. The majority of intrapartum transfers were for failure to progress, and only 4.5% of the total sample required oxytocin augmentation and/or epidural analgesia. The rates of spontaneous vaginal birth, assisted vaginal birth, and cesarean were 93.6%, 1.2%, and 5.2%, respectively. Of the 1054 women who attempted a vaginal birth after cesarean, 87% were successful. Low Apgar scores (< 7) occurred in 1.5% of newborns. Postpartum maternal (1.5%) and neonatal (0.9%) transfers were infrequent. The majority (86%) of newborns were exclusively breastfeeding at 6 weeks of age. Excluding lethal anomalies, the intrapartum, early neonatal, and late neonatal mortality rates were 1.30, 0.41, and 0.35 per 1000, respectively.

 https://onlinelibrary.wiley.com/doi/pdf/10.1111/jmwh.12172

EVIDENCE

- Home vs Hospital: for mothers
  - Increase maternal satisfaction
  - Decreased medical interventions
  - Decreased cesarean rate
  - Increased likelihood of unmedicated birth
  - Increased risk of postpartum hemorrhage

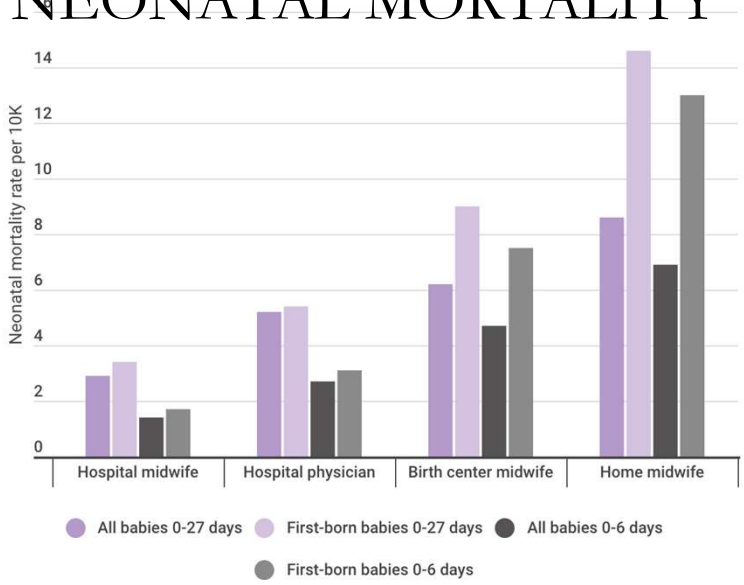
RATES COMPARED

MANA Stats	CDC Wonder
2.06/1000	0.7/1000 mortality
Breech	
22.5/1000	1.8/1000
TOLAC	
4.75/1000	0.7/1000
PPH	
15.5%	3.3%

EVIDENCE

- Home vs Hospital: for babies in FTD analysis
  - Increased risk of seizures
  - Increased risk of HIE
  - Tripled mortality rate overall

NEONATAL MORTALITY



REGULATION

- Licensure versus Certification
- TDLR - Texas Midwives Advisory Board
- NARM

Texas Licensure

- Application
- NARM exam
- Satisfactory education course (PEP accepted)
- Current certification in CPR for professionals and NRP
- Newborn Screening collection training
- Pay a fee
- Pass TDLR jurisprudence exam
- Criminal background check

BIRTHING CENTERS

- Regulated by the Health Facility Compliance Group

https://www.dshs.texas.gov/facilities/compliance-contact.aspx

- 77 centers in Texas

http://gatehousenews.com/failuretodeliver/explore-the-database/#birthcenters

When Things Go Wrong

Hospital

- Peer Review
- Medical/Nursing Board
- Malpractice Insurance

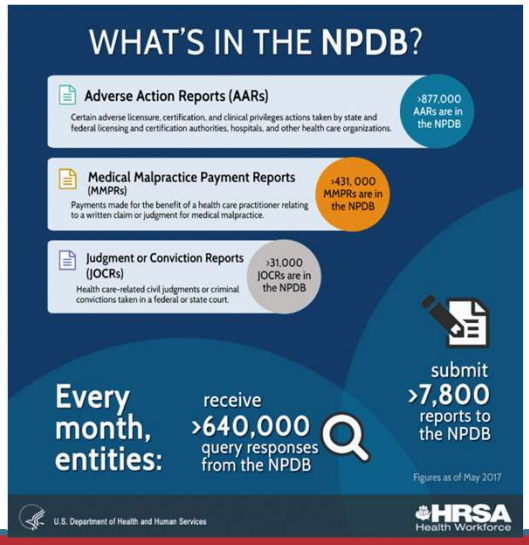
Home Birth

- File complaint to TDLR
- Voluntary peer review if maintaining credential
- Malpractice Insurance??

Penalties

- Practicing medicine without a license is a felony
- Practicing nursing without a license is a felony
- Practicing midwifery without a license currently carries no civil or criminal penalty as of September 2017.

When Things Go Wrong



STANDARDS OF CARE

- Exist in every area of medicine and nursing
- 200 ACOG Practice Bulletins, 30+ from ACNM

NARM Statement

"...each midwife is an individual with specific practice protocols that reflect her own style and philosophy, level of experience, and legal status, and that practice guidelines may vary with each midwife. NARM does not set protocols for all CPMs to follow, but requires that they develop their own practice guidelines in written form".

PRENATAL CARE

Assess for and *refer* to physician or delegate of physician for:

- infection requiring abx
- Hepatitis
- non-insulin dependent DM
- thyroid disease
- current drug or alcohol abuse
- asthma,
- abnormal pap smear during the current pregnancy
- seizure disorder
- prior cesarean (classical or vertical incision requires *transfer of care*
- Multiple gestation

REFERRAL CONTINUED

- - Hx miscarriage, neonatal death, any congenital malformation or genetic disorder
- - significant vaginal bleeding
- maternal age less than 15 at EDC
- cancer or hx cancer
- psychiatric illness
- any other condition or symptom which could adversely affect the mother or fetus, as assessed by a midwife exercising reasonable skill and knowledge

PRENATAL CARE - TRANSFER

- placenta previa in the third trimester;
- Human Immunodeficiency Virus (HIV) positive or Acquired Immunodeficiency Syndrome (AIDS);
- cardio vascular disease, including hypertension, with the exception of varicosities;
- severe psychiatric illness;
- history of cervical incompetence with surgical therapy;
- pre-term labor (less than 37 weeks);

TRANSFER CONTINUED

- previous uterine surgery involving incision into the uterine myometrium, other than a low transverse cesarean section
- preeclampsia/eclampsia;
- documented oligo-hydramnios or poly-hydramnios;
- any known fetal malformation;
- Preterm Premature Rupture Of Membranes (PPROM);
- intrauterine growth restriction
- insulin dependent diabetes;

TRANSFER CONTINUED

- triplet or higher order multiple gestation;
- Rh or other blood group isoimmunization;
- active cancer history or history of ovarian, breast, uterine, or cervical cancer;
- undiagnosed vaginal bleeding lasting longer than two weeks, or;
- any other condition or symptom which could threaten the life of the mother or fetus, as assessed by a midwife exercising reasonable skill and knowledge

TRANSFER CONTINUED

- If a client has reached **42.0 weeks gestation** and is not yet in labor, the midwife must immediately either:
- *collaborate* with a physician and obtain appropriate antenatal testing, in order to continue midwifery care; or
- initiate transfer and document that action in the midwifery record.

CANDIDATES FOR HOME BIRTH

CONDITION	TEXAS	THE NETHERLANDS
PRIOR CESAREAN	YES	NO
HYPERTENSION	NO	NO
DIABETES	YES	NO
TWIN GESTATION	YES	NO
BREECH PRESENTATION	YES	NO
NULLIPAROUS (FIRST DELIVERY)	YES	YES*
POSTDATES (42+ WEEKS)	YES	NO
> 24 HRS RUPTURED MEMBRANES	YES	NO

* PRIMIPAROUS WOMEN ARE CANDIDATES FOR DUTCH HOME BIRTH, BUT THE RISK OF INJURY OR DEATH FOR MOTHERS AND BABIES IS SIGNIFICANTLY HIGHER

TRANSFERS

During Labor, Emergency transfer if…

- prolapsed cord;
- chorio-amnionitis (infection inside the uterus of the placenta or amniotic fluid);
- uncontrolled hemorrhage;
- gestational hypertension/preeclampsia/eclampsia;
- severe abdominal pain inconsistent with normal labor;
- a non-reassuring fetal heart rate pattern;

TRANSFERS CONTINUED

- thick meconium unless the birth is imminent;
- visible genital lesions suspicious of herpes virus infection;
- evidence of maternal shock;
- preterm labor (less than 37 weeks);
- presentation(s) not compatible with spontaneous vaginal delivery;
- laceration(s) requiring repair beyond the scope of practice of the midwife;

TRANSFERS CONTINUED

- Seizure;
- failure to progress in labor;
- retained placenta; or
- any other condition or symptom which could threaten the life of the mother or fetus, as assessed by a midwife exercising reasonable skill and knowledge

WHAT IS A TRANSFER?

- Transport to hospital by personal vehicle
- Call 911, provide care until they arrive
- Update the receiving clinician/hospital regarding case
- Statutes list a number of conditions for both mother and baby

TRANSFER ISSUES

- Fear
- Animosity
- Poor handoff
- Continuity

TRANSFER GUIDELINES

- Home Birth Summit – Best Practices

http://www.homebirthsummit.org/wp-content/uploads/2014/03/HomeBirthSummit_BestPracticeTransferGuidelines.pdf

- Collaboration, not hostility
- Standard SBAR, forms online
- Continuity preserves

Safe Home Birth in Texas

- Advocacy
- Education and Training
- Strict regulation
- Statewide data capture for analysis
- Standards of Care
- Malpractice insurance
- Niche for Family Docs

Objectives for THB.com

Create an evidence-based web resource that

- Adequately explains the risks, standards, and regulation of the practice in Texas
- Understandable and palatable for patients in the "natural birth" community
- Is informative for clinicians

What should you do?

- Make sure parents understand risks
- Recommend appropriate resources [www.TexasHomeBirth.com]
- Know who's who in your community
- Advocate for changes to make OOH birth safer
- Support a culture of safety and smooth transfer

All sources available at www.texashomebirth.com