WARM Considerations for Care, Consultation, and Referral

Introduction:

Community Based Midwives engage in an ongoing screening process from the initial contact with a client through the completion of postpartum care. Midwives take into account client autonomy and informed choice, applicable laws and regulations, research and medical literature, standards of practice for care, the setting in which they practice, collaborative relationships with other health care practitioners and facilities, and the basic core competencies of midwifery care while integrating their own clinical judgment, training, expertise, and philosophy of care.

Complications may develop during the course of care and this document provides a framework for the involvement of other health care practitioners when needed. Circumstances may arise where the midwife believes discussion, consultation, or transfer of care is appropriate.

Appendices with conditions that a midwife may encounter where further risk assessment may be indicated is also provided. These lists are not exhaustive and do not seek to itemize every possible condition, but rather provide a representative framework for the critical thinking of midwifery care.

The Washington Alliance for Responsible Midwifery (WARM) recognizes that autonomous midwifery in the State of Washington is a primary care practice under the Revised Code of Washington (RCW) 18.50 and that midwives provide care within their scope of practice, including the responsibility for recognizing conditions that indicate a need for more information or clinical care with another practitioner. Midwives work to promote the optimal health and safety of mothers and babies during the normal childbearing cycle. When there are significant deviations from normal during the pregnancy, labor, or postpartum period, midwives include consultation as a part of standard of care as needed.

WARM developed this document with input from a variety of midwifery-based sources, including other countries with well-functioning, highly-integrated midwifery, homebirth, and community-based health settings. This document also seeks to enhance safety, promote midwifery accountability to their clients, and provide for trusting relationships with other health care practitioners and the general public. Changes to this document will be based on research, experience, and ongoing evaluation of midwifery practice to ensure the relevance of the standard to provide safe and effective midwifery care.

Purposes:

- To give guidance to community midwives and their clients regarding potential consultation, referral, co-care, and/or transfer of care.
- To further the understanding of community midwifery care.
- To facilitate the process and considerations when: undertaking a transfer of care from a primary or community-based setting to another practitioner.

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Definitions:

For the purpose of this document, the following definitions apply:

WARM recognizes that consultation and referral may include a wider variety of care practitioners and it is up to the midwife's best clinical judgment in conjunction with shared client decision-making to provide the appropriate next steps in care. Consultation and referral may include but are not limited to, other midwives, individual practitioners such as massage therapists, chiropractors, physical therapists, lactation consultants, maternal fetal medicine (MFM), certified nurse-midwives, obstetricians, and/or pediatricians and neonatologists or other licensed specialty practitioners.

Consultation with another practitioner "refers to the situation where a midwife requests the opinion of a consultant competent to give advice regarding the issue."(Manitoba) and may include sharing clinical care information to determine an action or recommended course of care, or to garner more information about a specific condition, without a transfer of primary clinical care. Consultation may be via phone, telehealth, email, or in person.

Referral can be offered to the client to seek another practitioner to screen, assess, or treat for specific symptoms and/or condition, with or without a transfer of primary clinical care.

Co-care is the shared clinical care of a single client between two or more practitioners in agreement with the client pursuing specific health outcomes or goals.

Transfer of care is the transfer of clinical responsibility of care to another practitioner. This may occur at any time during pregnancy, labor, postpartum, or for further infant care. This may or may not involve physical transfer of the client at the time of the transfer of care.

Considerations specific to midwifery practice:

It is important to note that the severity of the condition may present the opportunity to assess risk with another practitioner, consult for treatment, pursue co-care, and/or complete transfer of care for the duration of the illness, condition, and/or the pregnancy, based on client preference and shared decision-making.

- Shared decision-making is the obstetrical and midwifery standard of care. WARM acknowledges the foundational rights of clients to autonomy and choices in care. The American College of Obstetrics and Gynecologists (ACOG) clearly state in their Ethics Committee Position #390, "In the obstetric setting, recognize that a competent pregnant woman is the appropriate decision maker for the fetus that she is carrying."

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- Licensed midwives in Washington are required 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 a woman to an appropriate obstetrical department or patient care area. The written plan shall be submitted annually together with the license renewal fee to the department." (RCW 18.50.108)
- Transfers ideally includes the midwife as a part of care, seeking to collaborate with the receiving care practitioner, to facilitate client continuity and safety.
- Dual- or multi-licensed practitioners practice within the greater scope of those licenses and may differ in appropriate guidance for their unique practices.
- Consultations may be initiated upon request of the client
- Client autonomy being the right of clients to make decisions about their health care without their practitioner trying to influence the decision. Client autonomy allows for practitioners to educate the client but does not allow the practitioner to make the decision for the client.
- The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes.

  The Midwives Model of Care includes:

  - Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
  - Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
  - Minimizing technological interventions
  - Identifying and referring women who require obstetrical attention
  - The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

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Potential indications for further assessment

The clinical indications of any given condition present the opportunity of offering risk assessment to the client and/or another provider, consult for treatment, pursue co-care with both providers, and/or complete transfer of care for the duration of the illness, condition, and/or the pregnancy, based on client preference and shared decision-making

Appendices

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Appendix A: Client Health History

Some client health history that may indicate a need for further risk assessment, consultation, and/or transfer of care:

Family history of genetic disorders, hereditary disease, significant congenital anomalies, or a positive genetic screening

History of 3 or more consecutive spontaneous abortions (College of Midwives of Manitoba, Ministry of Health)

History of >1 late miscarriage after 14 weeks (College of Midwives of Manitoba)

History of >1 preterm birth or preterm birth of less than 34 weeks (College of Midwives of Manitoba)

History of >1 small for gestational age (SGA) newborn less than 3rd percentile (College of Midwives of Manitoba)

History of cervical cerclage or incompetent cervix

History of hypertensive disorder of pregnancy

History of >1 Cesarean section or previous uterine surgery (College of Midwives of Manitoba)

Previous stillbirth or neonatal loss which likely impacts current pregnancy

Abnormal cervical cytology requiring further evaluation

Uterine malformation/disorders or fibroids with potential impact on pregnancy

Chronic physical or mental health condition requiring treatment and/or monitoring

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Appendix B: Antepartum

Some antepartum indications that may indicate a need for further risk assessment, consultation, and/or transfer of care:

Sexually transmitted and blood borne infection requiring treatments that are not within the scope of midwifery practice

Development of a physical or mental health condition requiring treatment and/or monitoring

Molar or ectopic pregnancy

Hyperemesis unresponsive to treatment

Recurrent or unresponsive UTI or acute pyelonephritis

Persistent vaginal bleeding of unknown origin

Preterm Premature Rupture Of Membranes

Hypertensive disorders of pregnancy

Thrombophlebitis or suspected thromboembolism

Isoimmunization

Primary genital herpes

Documented vasa previa

Gestational diabetes requiring pharmacologic treatment

Intrauterine fetal demise

Placental abruption

Placenta previa or low-lying placenta persistent into third trimester

Suspected or diagnosed fetal anomaly that may require management during or immediately after delivery

Abnormal fetal assessment

Suspected or documented IUGR, SGA

Oligohydramnios or polyhydramnios

Persistent transverse lie at term

Pregnancy lasting longer than 43 + 0 (Oregon Secretary of State Administrative Rules)

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Appendix C: Intrapartum/Labor

Some intrapartum or labor indications that may indicate a need for further risk assessment, consultation, and/or transfer of care:

Labor or premature rupture of membrane less than 36+0 (Oregon Secretary of State Administrative Rules)

Active genital herpes

Suspected pre-eclampsia, eclampsia or HELLP syndrome

Suspected placental abruption, placenta previa

Suspected intrauterine infection

Suspected uterine rupture

Suspected embolism

Hypovolemic shock

Fetal bradycardia, tachycardia, or heart rate decelerations unresponsive to management

Prolapsed or presenting cord

Maternal request for transfer

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Appendix D: Postpartum

Some postpartum indications that may indicate a need for further risk assessment, consultation, and/or transfer of care:

Hemorrhage unresponsive to treatment

Hypovolemic shock

Retained placenta or tissue

Lacerations involving the anus, anal sphincter, rectum, urethra or considered 3rd or 4th degree

Significant hematoma

Uterine prolapse or inversion

Seizure

Anaphylaxis

Thrombophlebitis, thromboembolic disease, or suspected thromboembolism

Unexplained persistent chest pain or dyspnea

Subinvolution of the uterus with signs and symptoms of uterine infection

Wound infection unresponsive to treatment

Breast infection or recurrent mastitis unresponsive to treatment

Uterine infection or endometritis

Persistent UTI unresponsive to treatment

Persistent bladder or rectal dysfunction

Persistent or new onset hypertension, postpartum eclampsia

Secondary postpartum hemorrhage

Anemia unresponsive to treatment

Postpartum Mood Disorders unresponsive to therapies

Significant mental health concerns presenting or worsening during postpartum

Abnormal cervical cytology requiring treatment

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Appendix E: Newborn Care

Some newborn and/or general indications that may indicate a need for further risk assessment, consultation, and/or transfer of care:

Low APGAR (<7 at 10 minutes) with no improvement

Neonatal Resuscitation measures involving chest compressions or prolonged PPV

Visually apparent or suspected congenital anomalies or abnormal number of umbilical vessels not consulted for prenatally

Apparent or suspected birth injury, excessive bruising, abrasions, unusual pigmentation/coloration, or lesions

Suspect Transient Tachypnea of the Newborn (TTN)

Persistent respiratory distress

Abnormal heart rate pattern or persistent/symptomatic murmur

Low Birth Weight 2270g, 5 pounds (Oregon Secretary of State Administrative Rules)

Signs or symptoms of hypoglycemia unresponsive to treatment

Suspected seizure activity

Persistent inability to maintain normal newborn temperature (hyperthermia, hypothermia, or instability)

Infant born to an individual with current significant drug or alcohol use in utero, exposure to significant drugs, alcohol, or other substances with known or suspected teratogenicity

Infant born to an individual who is HIV or syphilis positive or who has active genital herpes at the time of birth

Hyperbilirubinemia (jaundice) <24 hours of age

Hyperbilirubinemia (jaundice) >24 hours of age, non-resolving

Failed 2nd CCHD screening

Does not pass meconium, does not urinate within 36 hours (College of Midwives of Manitoba)

Difficulty with breastfeeding

>10% weight loss (Ministry of Health)

Worsening cephalohematoma

Suspicion of neonatal infection

Infection of the umbilical stump site unresponsive to treatment

Suspected or documented isoimmunization in the newborn

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Appendix F: References:

ACOG Committee Opinion No. 390. (2016). *Ethical decision making in obstetrics and gynecology*

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2007/12/ethical-decision-making-in-obstetrics-and-gynecology

College of Midwives of Manitoba. (2020). *Standard for consultation and transfer of care.*

https://midwives.mb.ca/document/5904/standard-for-consultation-and-transfer-of-care.pdf

Ministry of Health. (2012). *Guidelines for consultation with obstetric and related medical services (Referral guidelines).* Wellington: Ministry of Health

Revised Code of Washington (RCW) 18.50, Midwifery

https://app.leg.wa.gov/rcw/default.aspx?cite=18.50

Oregon Secretary of State Administrative Rules. (2020). *Health licensing office, board of direct entry midwifery – Chapter 332, division 25 practice standards.* Oregon Health Authority. https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1213

Washington Administrative Code (WAC) 246-843, Midwives.

https://app.leg.wa.gov/wac/default.aspx?cite=246-834

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