What kinds of questions do people in your community have about home births?

DISCLAIMER

- Watching this webinar does not mean that we have entered into a patient-care provider relationship.
- Nothing in this course shall be construed as medical advice.
- Talk with a care provider before putting this information into practice.
- Content is not guaranteed to be 100% accurate or up to date.

OBJECTIVES

- Discuss the research on home birth and how home birth is integrated into the health care systems in:
  - United Kingdom (U.K.)
  - Canada
  - United States (U.S.)

HOW WILL TODAY’S WEBINAR WORK?

- Evidence on home birth
- Resources
- Q&A
- Free Handout

OVERVIEW

This webinar is intended to provide an overview of the evidence on home birth in three regions. It is not a comprehensive review of all of the evidence on home birth.
HOME BIRTH INTEGRATION IN THE U.K.

- Home birth is well integrated
- Midwives licensed & regulated
- Midwives have admitting privileges
- Supportive obstetrical statements
- Home birth costs are publicly funded with NHS midwives

Cone et al. (2015) Birth

BIRTHPLACE IN ENGLAND STUDY— METHODS

- Prospective study
- 64,538 low-risk people with a single baby ≥ 37 weeks
- Included births planned at home (n=16,840), freestanding midwifery units (n=11,282), alongside midwifery units (n=16,710), and obstetrical units (n=19,706)
- No planned Cesareans or unplanned home births


BIRTHPLACE IN ENGLAND— KEY FINDINGS

- First-time and experienced mothers who planned birth OOH had lower rates of:
  - Cesarean
  - Vacuum/forceps
  - Labor augmentation
  - Episiotomy
- First-time mothers had more hospital transfers (45% vs. 12%)

BIRTHPLACE IN ENGLAND—KEY FINDINGS

• Overall 4.3 adverse newborn outcomes per 1,000 births
• Adverse newborn outcome = intrapartum stillbirth, early neonatal death, brain damage, meconium aspiration, birth injuries
• For people who had given birth before, there was no difference in adverse newborn outcomes in any setting


BIRTHPLACE IN ENGLAND—KEY FINDINGS

• First-time mothers had increased risk of an adverse newborn outcome with home birth vs. obstetrical unit birth (9.3 adverse events per 1,000 births vs. 5.2 per 1,000 births)


HOME BIRTH INTEGRATION IN CANADA

• Midwifery services vary by province and territory
• British Columbia and Ontario:
  • Home birth is well integrated
  • Midwives licensed & regulated; 4–yr baccalaureate program
  • Midwives have hospital privileges
  • Supportive obstetrical statements

Comeau et al. (2018); Hutton et al. (2016)

HUTTON ET AL.—METHODS

• Retrospective study using provincial database
• Registered midwives provided care
• 11,493 planned home birth and 11,493 planned hospital births
• Excluded medical conditions, >1 prior CS, medical induction, breech, multiples, <37 weeks (but not post-term)

Hutton et al. (2016)
HUTTON ET AL. - KEY FINDINGS

• Compared with planned hospital birth, people who planned birth at home:
  - More spontaneous vaginal birth (91% vs. 87%)
  - Less labor augmentation (31% vs. 39%)
  - Less likely to use pain meds (16% vs. 42%)

HUTTON ET AL. (2016) STUDY - KEY FINDINGS

• Defined outcome as combo of stillbirth, death, low Apgar scores at 5 min, or CPR
• No difference in the risk of death or other serious newborn health outcomes between settings
  ➢ Absolute risk of combined adverse outcome was 3.9 per 1,000 in each group
  ➢ These findings applied to both first-time mothers and experienced mothers
  ➢ Perinatal death rates were not significantly different (~1 per 1,000 in each group)

HOME BIRTH INTEGRATION IN THE U.S.

• 1% of U.S. births take place at home (88% planned)
• OOH birth more common in AK (7%), OR, MT, and WA (4%)
• 78% of attendants at planned home births are midwives
  ➢ 28% CNM/CM, 50% non-CNMC/CM (mostly CPMs)
• All 3 credentials accredited by national agencies
• ACOG discourages home birth, respects informed consent

OREGON (2.5% HOME BIRTH RATE)

• High level of midwifery integration
• Authorizes the practice of CPMs
• New licensure requirements for midwives in 2015
• Both CNMs and CPMs may bill Medicaid
• Easy access to referrals and hospital transfers

MacDorman & Declercq (2016); ACOG #687 (2017)
Snowden et al. (2015); Vedam et al. (2018)
SNOWDEN ET AL—METHODS

- Retrospective study
- Used birth certificate data from all births that occurred in Oregon during 2012 and 2013
- Included nearly 80,000 births
  - 75,000 planned hospital
  - 3,800 planned home birth

SNOWDEN ET AL—METHODS

- Compared planned OOH birth vs. planned hospital birth
- Did not distinguish between home birth and birth centers (but excluded physician’s offices, clinics)
- Excluded congenital anomalies, multiples, breech, births before 37 weeks gestation

SNOWDEN ET AL—KEY FINDINGS

- Compared with hospital group, people who had planned OOH births had:
  - Lower rates of induction (4.8% vs. 30.4%)
  - Lower rates of augmentation (7.5% vs. 26.3%)
  - Lower Cesarean rate (5.3% vs. 24.7%)
  - Fewer severe perineal lacerations (0.5% decrease in risk)
  - More blood transfusions (0.28% increase in absolute risk)

SNOWDEN ET AL—KEY FINDINGS

- Compared with planned hospital births, babies born during planned home births had:
  - Fewer NICU admissions (1.7% vs. 2.9%)
  - More perinatal deaths 3.9 vs. 1.8 per 1,000
  - More neonatal deaths 1.6 vs. 0.5 per 1,000
  - More 5-minute Apgar scores <4, -0.2% increase

WHY DIFFERENT RESULTS IN ONTARIO VS. OREGON?

- Fewer hospital transfers in OR (17% vs. 25%)
- Mix of providers in OR—licensed DEMs (55%), CNMs (10%), naturopaths (19%), family (4%), unlicensed DEMs (13%)
- More risk factors in Oregon planned home birth
- Self pay = disincentive to transfer

CHEYNEY ET AL. (2014) STUDY

• 89% completed birth at home
• Most transfers were for failure to progress or need for epidural (4.5% of sample)
• Low rate of postpartum maternal transfers, (1.5%) and newborn transfers (0.9%)


CHEYNEY ET AL. METHODS

• Midwives Alliance of North America (MANA), 2004-2009
• aka “MANA Stats”
• 16,924 people who planned home birth at the start of labor
• Clients enrolled early in pregnancy, before outcomes were known (prospective logging)


CHEYNEY ET AL. KEY FINDINGS

• Spontaneous vaginal birth rate (94%); CS rate 5.2%
• 87% VBACs were successful
• 86% newborns exclusively breastfed at 6 weeks, 98% partially breastfed
• 1 maternal death (blood clot on 3rd day)


CHEYNEY ET AL. KEY FINDINGS

• Intrapartum stillbirth = 1.3 per 1,000 (n = 22)
• Early neonatal death (0-6 days) = 0.41 per 1,000 (n = 7)
• Late neonatal death (7-27 days) = 0.35 per 1,000 (n = 6)
• When high risk people were removed, the overall risk of intrapartum stillbirth was 0.85 per 1,000
• Combined intrapartum and neonatal death rate:
  • 2.86 per 1,000 planned home births (includes all births)
  • 1.61 per 1,000 planned home births excluding higher risk births


COMPARING HOME TO HOSPITAL IN THE U.S.

• It is not possible to piece together an appropriate hospital comparison group using CDC data
• U.S. does not collect data on intrapartum mortality
• Home birth families have higher cultural tendency to decline prenatal genetic testing, termination, and autopsy

BOVBJERG ET AL. (2017) STUDY— ‘HIGHER’ RISK

- Secondary analysis of MANA Stats data
- Overall risk of perinatal death 1.98 per 1,000 planned OOH births
  - Breech (16.8 per 1,000)
  - Preeclampsia (16.1 per 1,000)
  - Prior Cesarean and no prior vaginal births (10.3 per 1,000)
  - First-time mother (3.0 per 1,000 births)
  - Prior CS AND prior vaginal birth (1.5 per 1,000; 93% completed VBAC)

SAFETY OF PLANNED HOME BIRTH DEPENDS ON:

MATERNAL AND PREGNANCY RISK FACTORS

Lowest risk = healthy, prior vaginal birth, vertex, term

ATTENDANT QUALIFICATIONS

Trained in OOH birth, credentials, practice patterns, transfer plan

INTEGRATION WITH THE HEALTH SYSTEM

Access to referrals and prompt hospital transfer without legal, geographic, cultural, financial barriers

Thoughts about this info?

RESOURCES FOR YOU

www.evidencebasedbirth.com

RESOURCES FOR PARENTS:

www.evidencebasedbirth.com

Putting current Evidence Based information into the hands of Communities, so they can make Empowered Choices

RESOURCES FOR PROFESSIONALS:

Putting current Evidence Based information into the hands of Communities, so they can make Empowered Choices
EBB PROFESSIONAL MEMBERSHIP

- Professionals who want to change the world!
- Earn relevant CEUs in an inter-professional environment
- Get behind the scenes of EBB

INCLUDED IN YOUR MEMBERSHIP:
- All our continuing education courses
- Live monthly trainings (+ recordings!)
- Private community
- Video + PDF Library
- Access to Rebecca

CONTINUING EDUCATION FOR:
- Nurses
- Doulas
- Childbirth educators
- CPMs, CNMs, CMs
- Midwifery Bridge Certificate (18 hours)
- Physicians

AVAILABLE CLASSES:
- Help Families get Evidence Based Care (7 hours)
- Big Babies & Gestational Diabetes (3 hours)
- Due Dates & Advanced Maternal Age (3 hours)
- Failure to Progress (2 hours)
- Vitamin K & Eye Ointment (2 pharm hours)
- Overturning Hospital Bans (3 hours)
- PROM, GBS, & Newborn Procedures (3 hours)
MONTHLY + ANNUAL DISCOUNT

MONTHLY
$49
$39.20
Per Month

ANNUAL
$447
$357.60
Per Year

** THROUGH MAY 8 2018 ONLY

SCHOLARSHIPS

✓ Scholarships for midwifery, nursing, and medical students
✓ Scholarships for persons of color

GROUPS

✓ Enrollment is OPEN through April 2018
✓ Available at monthly and annual rates
✓ 20% off for groups of 3+ | 25% off for groups of 10+
✓ Each member pays individually and gets their own unique login and password
✓ Next group enrollment period is in October

UNIVERSITY ACCESS

✓ Already used by midwifery and doula university programs across the U.S. and Canada
✓ Perfect for nursing, midwifery, doula, medical school, gender studies, and family studies faculty who want to incorporate official Evidence Based Birth® content into their courses.

QUESTION & ANSWER

FREE HANDOUT
THANK YOU.