AIM

ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Community Birth Transfer Resource Kit

August 2024

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Resource Kit Scope and Frequently Asked Questions

Planned community births—which, for the purposes of this resource kit, are defined as planned home births or births in freestanding birth centers—are steadily becoming more common in the United States. Currently 2%, or 1 in every 50 births in the US, is a planned community birth, and the rate is expected to continue increasing.[1] Rates of community birth vary considerably across states and regions.

Most planned community births begin and conclude at their intended location; however, approximately 10–25% involve intrapartum or postpartum transfer of care to a hospital for neonatal or maternal considerations.[1,2,3] Safe and timely transfer of care, when needed, is key to ensuring high-quality and equitable outcomes.

When transfer is needed, community birth providers, emergency medical services (EMS), and receiving hospital providers and staff must function as a coordinated care team. Structural and systemic barriers exist that limit the use of training, protocols, and collaborative programming. Programs to facilitate teamwork are essential to support safe and timely transfers. This resource kit describes current best practices and resources to support and facilitate transfer from a community birth to a hospital.

Many community birth-to-hospital transfers are not emergencies. At times, this resource kit focuses more heavily on optimizing care in emergency transfers, which are more likely to cause or contribute to maternal mortality and severe maternal morbidity (SMM). This focus aligns with the mission and vision of the developing entity, the Alliance for Innovation on Maternal Health (AIM).

Navigating the Resource Kit

This resource kit is segmented into specific best practices that parallel the format and categories used in AIM patient safety bundles (PSBs): readiness, recognition and prevention, response, reporting and systems learning, and respectful care. More than one section begins with a discussion of communication and collaboration as a foundational and essential component to all patient care. Under each section are discrete elements of quality improvement (QI) interventions that teams may undertake to improve processes and procedures related to the community birth transfer process.

Use

The sections of this resource kit can be used in their entirety or independently for specific QI endeavors. Each section provides information and resources to build systems and structures to deliver evidence-informed care. The resource kit also shares examples of guidelines, protocols, and practices to improve standardization of procedures and communication, which may reduce patient harm. All resource kit components are descriptive rather than prescriptive and users should customize the resources to fit their local context and to align with clinical judgment. This resource kit is not intended to be a response manual; rather, it provides background and resources to teams for review, planning, prioritization, and adaptation to their needs and specific clinical settings in advance for all involved in the transfer process.

Resources indicated by this symbol are materials that are ready for immediate use by providers, facilities, and health systems.

Examples indicated by this symbol are models of programs, agreements, protocols, and checklists that can be reviewed and adapted to needs and clinical settings.

Equity

Because high-quality care is not possible without equitable care, centering equity and addressing racism and bias in care while undertaking QI is crucial. Respectful, equitable, and supportive care concepts are integrated throughout each section of this resource kit and explicitly addressed in the **Respectful, Equitable, and Supportive Care** section. Users are encouraged to prioritize input from patients and families with lived expertise when implementing elements of this resource kit.

Gender-Inclusive Language

The authors understand that people who are pregnant, birthing, postpartum, and parenting have a range of gender identities and do not always identify as "women" or "mothers." In recognition of the diversity of identities, as well as the American College of Obstetricians and Gynecologists' **(ACOG's) Inclusive Language Statement of Policy**, this document attempts to give preference to gender-neutral terms such as "people," "pregnant people," and "people who are pregnant or postpartum."[4] When referencing source material that uses gendered language, the terminology of the original authors and research has been retained.

Who should use this resource kit?

The resource kit is best used by teams preparing to start QI initiatives and collaborative work related to community birth transfer of care. Any QI recommendations in this resource kit may be implemented by community birth providers, as well as by facility-based or regionalized multidisciplinary teams that may include clinicians, administrators, QI professionals, and other health care team members. Individual providers and community birth stakeholders may use the resource kit for professional development and to prepare themselves to be champions for safe birth transfer practices in their own communities.

How was this resource kit prepared?

To develop this resource kit, AIM convened a multidisciplinary team comprising subject matter experts to inform the content. AIM collated resources and information into sections, identifying specific best practices that parallel the AIM PSB format and categories. Finally, the multidisciplinary team and other experts in emergency services and QI reviewed the resource kit content and suggested further refinements. See the **Acknowledgements** section for those involved in the development of the resource kit.

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Introduction

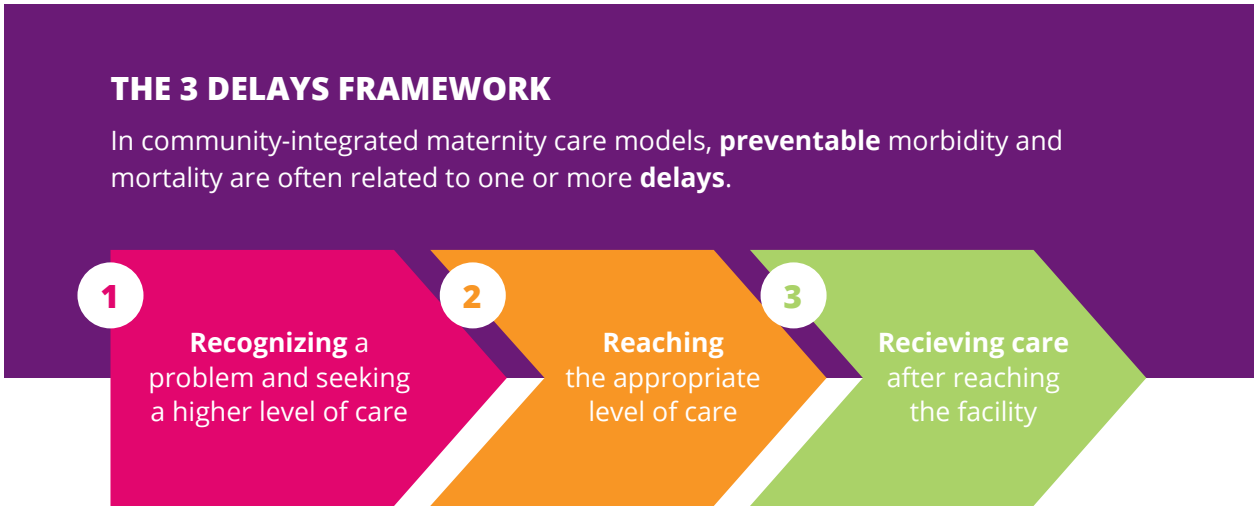
Families in the United States may give birth with a range of perinatal care providers in hospitals, freestanding birth centers, or homes. Regardless of birth location or care model, high-quality, safe care is essential to optimize perinatal outcomes. Creating systems that may facilitate collaboration in care, regardless of birth setting, is a fundamental component to improving the safety and quality of care provided to all patients.

In this resource kit, "community birth" refers to planned birth at home or in a freestanding birth center, most commonly in a midwifery model of care.

Framing Community Birth Transfer

Transfers from planned community births to hospitals when needed are an expected and important part of community birth. Whether because of evolving patient preference, clinical need, or for emergency care, appropriate and timely transfer of care requires the alignment of care team goals, centered in patient preferences and values. It should be noted that an increase in the rate of community birth transfers in a practice, community, or state may be a measurable result of transfer improvement work, as a focus on QI may increase awareness of conditions or facilitate processes that were needed but previously limited in clinical care.

Minimizing delays is essential when a need for transfer of care is identified. Delays in diagnosis and treatment, even within a hospital-based perinatal care setting of emerging clinical conditions, are the most consistent factors leading to maternal mortality and morbidity.[1] Delays may also present a risk in community birth settings, as modeled in the global health model describing contributing factors to maternal mortality, the Three Delays Framework:



To prevent all three types of delays, methods are needed to ensure appropriate assessment and decision making about initiating transfer to optimize safe and timely transport and to ensure hospital-based interventions are patient-centered and appropriate. Communication and teamwork across the continuum of care are crucial for minimizing delays and optimizing outcomes.[2]

Examples of Reports on the Need for Transfer Improvement

- **Utah Women and Newborns Quality Collaborative: Utah Planned Out-of-Hospital Births in Utah, 2013–2015: A Descriptive Review (includes recommendations, published 2018):** This report is the second in a series of reports on planned out-of-hospital (OOH) births in Utah. This report reviews trends and describes maternal and infant outcomes.
- **Oregon Community Birth Transfer Partnership: Community Birth Transfer Survey Report (includes recommendations; see p. 59 of Transfer Improvement Toolkit)**
- **U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of Minority Health: Response to Request for Information Regarding Maternal and Infant Health Care in Rural Communities:** This transfer survey report (reflecting 119 survey responses) is rich with qualitative data reflecting family/consumer experiences of community birth transfer and hospital care. Themes and recommendations for improving community birth transfers are shared.

Midwifery Community Birth Providers

Families planning a community birth in the United States have options for care by a variety of community birth providers but are primarily cared for by midwives in a midwifery model of care. The Midwives Model of Care, as detailed by the National Association of Certified Professional Midwives, includes the following[3]:

- 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 obstetric attention

The American College of Nurse-Midwives describes a Philosophy of Midwifery as follows:

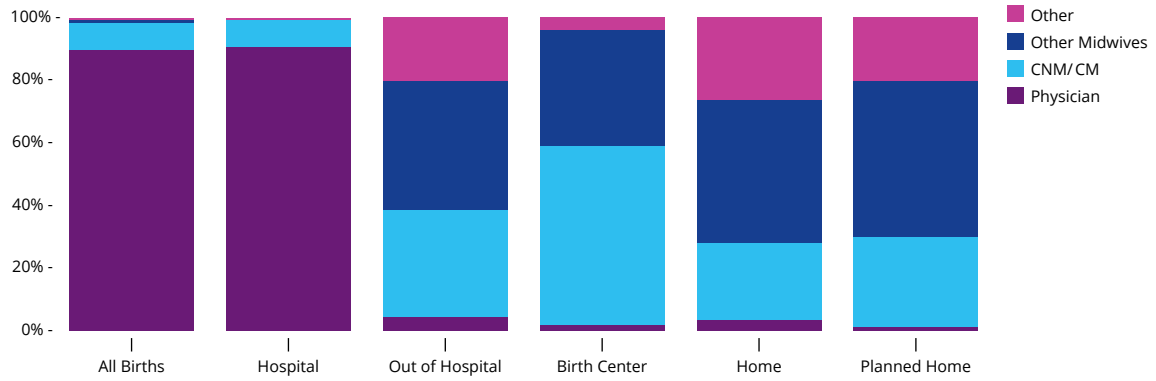
- Includes the full scope of health across the lifespan.
- Involves a continuous and compassionate partnership between persons seeking care and their health care providers.
- Recognizes the importance of interdisciplinary, collaborative care.
- Respects the individual's absolute right to bodily autonomy.
- Honors a person's expertise, life experiences, community, and historical knowledge.
- Includes methods of care and healing guided by research and best available evidence, centered on the individual's decisions, values, and preferences.

- Balances watchful waiting and support of physiologic processes with the appropriate use of interventions and technology.
- Involves therapeutic use of human presence and skillful communication.

Scope of practice, education pathways, and licensure for each provider and midwife type vary by state and are regulated in different ways. However, because the majority of community birth providers identify as midwives, this document refers to midwifery care throughout. Perinatal care for community birth settings may be provided by midwives holding various certification types and training types, such as licensed midwives, indigenous midwives, faith-community-affiliated midwives, and, less commonly, physicians.

Percentage of Births Attended by Physicians, Certified Nurse-Midwives (CNMs)/ Certified Midwives (CMs), and Other Midwives by Place of Birth, U.S., 2017

SOURCE: MacDorman and Declercq, 2019.



NOTES
Home: Does not include planned home births that were transferred to hospitals.
Planned Home: Does not include planned home births that were transferred to hospitals. Excludes data from California, which did not report the planning status of home births.

Other Community Birth Attendees

Doulas may also be present at community births. Doulas are trained professionals who provide continuous physical, emotional, and informational support before, during, and shortly after birth, but do not offer clinical care.[5,6] Midwifery students may also attend births, participating at various levels of care, but are supervised by the primary midwife. Some families choose a planned unassisted birth, or "freebirth," where there is no trained midwife or provider present. At planned unassisted births the attendees may be family members, friends, or other support people.

Freestanding Birth Centers

Freestanding birth centers refer to centers where births occur that are not co-located in a hospital perinatal setting or a patient's home. As with provider models and licensure in perinatal care, state and jurisdiction recognition and regulation of freestanding birth centers vary; some regions do not regulate or recognize them.

The American Association of Birth Centers stewards a multidisciplinary process to establish and maintain standards for care in freestanding birth centers and hospital-based birth centers. These standards form the basis of accreditation from the Commission for the Accreditation of Birth Centers, an independent, not-for-profit organization dedicated to birth center quality. The American Association of Birth Centers offers a best practice toolkit that includes model regulatory language that aligns licensure with birth center standards and accreditation.[6]

Birth Setting Choice and Risk-Appropriate Care

Risk-appropriate setting in perinatal care is an important concept to optimize patient safety and high-quality care. Comprehensive assessment of risk ensures that people who are pregnant and their fetus or neonate receive timely care from a professional who is prepared and has resources to meet the level of care needed.[7, 8]

Rather than a one-size-fits-all model, providers should partner with patients to assess the specific characteristics, values, and needs associated with each individual pregnancy and birth. These characteristics may encompass a range of factors, including maternal health history and current maternal medical and fetal conditions, patient preference, values, and social and structural drivers of health. The historical legacy of obstetric violence expressed though medical experimentation and abuse against Black, Indigenous, and other people of color (BIPOC), alongside present-day experiences of racism and bias in care can impact the sense of institutional trust and psychological and physical safety ascribed to various birth settings, especially for BIPOC patients.[9, 10]

Personal and societal historical and present-day factors mean that the process of birth setting choice and risk-appropriate care may often go beyond identifying individual patient risks; it involves a thorough consideration of multiple factors that together may result in compounded effects that influence the appropriate level of care required. Recognizing that patient-, provider-, environmental-, and system-level factors may all come into play in assessing risk is critical to determining the safest place for care and birth.

Hospitals providing perinatal care must continuously assess whether a facility provides the correct level of maternal and neonatal care to meet a patient's baseline and evolving needs. This assessment entails a holistic understanding of an individual's needs, as well as the capability and resources available to meet those needs. Similarly, a planned birth in a community setting should be evaluated in an ongoing way as a crucial aspect of risk-appropriate care.

Risk-appropriate care is best applied in a multifaceted and ongoing approach for all patients who plan to give birth. The approach should emphasize personalized risk evaluation and informed decision-making regarding selection of providers and birthing facilities, with awareness of resources available in each setting.

Patient Autonomy and Informed Decision Making

The principle of reproductive justice includes the "the human right to maintain personal bodily autonomy."[11] Respecting a pregnant person's right to bodily integrity and self-determination is a stated principle of midwifery associations and professional medical organizations involved in the provision of maternity care.[6, 12, 13]

Informed decision making is a reciprocal approach in which patients are provided with all pertinent information related to their health care and supported to choose the best options for themselves in accordance with their own values.[14, 15, 16] Among other things, these values may honor a person's cultural and religious beliefs and facilitate psychological safety.

Many organizations use the term "shared decision making" instead of "informed decision making" to describe the process of health care providers discussing information with patients to support them in making their own decisions. Some may interpret "shared decision making" as meaning that the ultimate decision reached is a shared responsibility between the health care provider and patient. The term "informed decision-making" clarifies that health care providers share information and support patients in making their own autonomous decisions, even if those decisions differ from provider recommendations. Although the term "informed decision making" is used in this resource kit, many resources may use the term "shared decision making." An approach that prioritizes patients accessing and discussing comprehensive information with health care providers about birth setting options and being supported in making autonomous, informed choices should be used in practice.

When applying this approach to decisions regarding birth settings and provider choice, health care professionals and patients should discuss patients' individual values and preferences, along with potential risks and benefits of each type of birth setting. While the professional brings expertise and clinical knowledge to the encounter, patients bring their own expertise and knowledge as well as their lived experience. This balance of expertise allows patients to engage in dialogue about their options and ask questions to support an autonomous, informed decision about the setting of care that best aligns with their individual needs and goals.[16]

In seeking to facilitate balanced dialogue regarding birth setting choice, it is important to recognize the imbalance of power between patients and providers that exists across care models. This imbalance is even greater for patients who have one or more historically marginalized identities and acts as a barrier to actualizing patient autonomy in birth setting decisions. It can also influence a patient's preferences and choices regarding birth settings.

All who are seeking to optimize community birth transfers should critically analyze the ways in which patients and their support networks are empowered or disempowered in the decision-making process and the ways that race, sex, gender, disability, language, and other identities impact how patients' autonomy is realized. This analysis should result in an active effort to seek methods and strategies to provide more equitable care and patient communication: ideally it should encourage individual providers to continuously examine their own personal racist ideas and biases. Every person in a care team should seek personal and professional education and hold each other accountable in working toward antiracism and an increased understanding of structural and social limitations to fully integrating equity into care.

The right to select a birth setting, including a planned birth at home or in a freestanding birth center, is supported by both national and international maternal-child health organizations. The American College of Nurse-Midwives' position statement on planned home birth asserts that "every woman has a right to shared decision-making regarding place of birth, and planned home birth should be accessible to healthy women who desire to give birth at home."[12] While ACOG maintains that hospitals and accredited birth centers are the safest settings for birth, the ACOG Committee Opinion, Planned Home Birth, states that "each woman has the right to make a medically informed decision about delivery."[13]

The guidance also identifies several factors specific to home birth that are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes, including the following:[13]

- The appropriate selection of candidates for home birth
- The availability of a certified nurse-midwife, certified midwife, or midwife whose education and licensure meet International Confederation of Midwives' Global Standards for Midwifery Education, or a physician practicing obstetrics within an integrated and regulated health system
- Ready access to consultation
- Access to safe and timely transport to nearby hospitals

A 2020 report on birth settings from the National Academies of Sciences, Engineering, and Medicine found that the safety of risk-appropriate community maternity care and birth offered specifically by a range of midwifery providers has been shown to be optimized when:[6]

- midwives are able to practice the midwifery model of care and to their full scope;
- midwives have legal access to medications and equipment as well as ongoing training;
- midwives are integrated into health care systems and integrated and valued as part of the team;
- midwives and health system team members establish functional systems for consultation, collaboration, and transfer of care; and
- all provider types participate in QI efforts.

Resources for Patient Education on Risk-Appropriate Care

- **Board on Children, Youth, and Families; Institute of Medicine; National Research Council: Assessment of Risk in Pregnancy, in** An Update on Research Issues in the Assessment of Birth Settings: Workshop Summary: This workshop summary shares research findings of the effects of maternal care services in various birth settings.
- **Midwives' Association of Washington State:** Indications for Discussion, Consultation, and Transfer of Care in Home or Birth Center Midwifery Practice.: This document provides a list of conditions that a midwife may encounter in practice and intended to be used as a screening tool.
- Alaska Birth Transfer Initiative: This slide deck includes risk factors associated with maternal and neonatal transfer (slides 16 and 18).
- **Risk selection for appropriate community birth candidates:**
  - **Oregon Community Birth Transfer Partnership:** Transfer Improvement Toolkit: Appendix C: Family/Consumer Research and Feedback (p. 43)
  - Utah Women and Newborns Quality Collaborative Out of Hospital Births Committee (reasons for community birth transfer)
- **Primary Maternity Care:** Hospital Guide to Integrating the Birth Center Model This guide collates tools, information, and resources for hospitals and health systems on integrating the freestanding birth center model. The resource includes steps for ensuring a prepared environment and birth team for each stage, including admission, second stage, birth, discharge, and transfer intrapartum, postpartum, or for newborn complications.

Examples of Reports on Birth Setting Choice

- **National Academies of Sciences, Engineering, and Medicine:** Birth Settings in America: Outcomes, Quality, Access, and Choice: This report examines various childbirth settings and associated outcomes within each.
- **National Partnership for Women & Families:** Improving Our Maternity Care Now: Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies This report reviews characteristics of midwifery care, community birth settings, doula support, and community-led and based perinatal health worker groups as care models and lends recommendations for decision makers in the private and public sectors.
- **National Partnership for Women & Families:** Improving Our Maternity Care Now Through Community Birth Settings: This area of the report discusses the value of community birth settings across different communities.

Examples of Shared Decision-Making Tools

- **Agency for Healthcare Research and Quality:** The SHARE Approach: This webpage provides and overview of a 5-step process for shared decision making with associated implementation tools.
- **American College of Nurse-Midwives:** Position Statement: Shared Decision-Making in Midwifery Care: This statement highlights the role of the midwife to be involved in all stages of care and reviews elements related to implementation of shared decision making.
- **American College of Nurse-Midwives:** Position Statement: Planned Home Birth: This statement outlines affirming attributes for well women, under the care of qualified providers, obtaining safe births in all settings.
- **American College of Nurse-Midwives:** Midwifery Provision of Home Birth Services: This statement outlines shared responsibility and informed choice for a home birth and elements to consider.

Example Shared Decision-Making Position Statement

- **Midwives' Association of Washington State:** Position Statement on Shared Decision-Making: This statement delineates shared decision-making with informed consent and informed choice.

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Readiness

Convene a Collaborative Team for Community Birth Transfer Improvement

Quality improvement work in health care relies on the input of all key stakeholder groups involved in the area of care being addressed. Convening and leading QI work may be best achieved by a perinatal quality collaborative or other state or regional QI team.

In establishing a QI team to optimize quality and safety of birth setting transfer, the following individuals and organizations should be included, although this list is not comprehensive:

Local, practicing clinicians from hospital and community birth settings

- Midwifery organizations
- Community members with lived expertise
- Community-based doulas
- Community organizations
- Birth center organizations
- Local or regional department(s) of health
- Perinatal and neonatal nursing and medical provider member organizations
- Hospital associations
- Medicaid and other payors
- First responder associations and personnel

Both hospital teams and community midwives should assess capacity and interest in taking on this shared QI work. The timing of a shared QI initiative should take these factors into consideration, as well as be planned around other facility and community factors, such as construction completion, leadership transitions, or new member training.

Assessing the status of care provided related to community birth transfer at an institution is an important first step to improving care. This assessment may include frequency, outcomes, barriers, and successes related to each transfer event. Relationships among internal and external team members involved in these processes should also be examined. Data may be collected through surveys, electronic medical record (EMR) audits, and chart reviews; ideally, patient perspectives on care received would also be included. See the **Reporting and Systems Learning** section for more information and examples.

Establish a Collaborative Workgroup and Plan

Hospitals, EMS, and community birth providers should engage with each other in active and proactive ways to develop transfer protocols, gather data, hold regular meetings to review data, solve problems, and build relationships. This engagement should include all community birth stakeholders, including doulas, childbirth educators, and community members with lived expertise, as noted previously. A communication list that includes midwives, community birth midwives and practices, and EMS providers in a community or service area should be determined to disseminate information in an inclusive manner. Ongoing communication is critical to disseminate protocols, especially when protocols are updated, and to encourage team members to fill out data collection tools, attend meetings where they participate in problem-solving, and become more familiar with community birth providers, community birth practices, and birth centers.

Clinical champions or leaders should be established for the QI team. A champion who works in the hospital setting and a champion who works in the community birth settings of care should be identified to work together as dyad QI team leadership. This dyad may model collaboration for the broader team and communicates the needs and accomplishments of the project to leaders in the hospital and the community, while providing leadership as the team sets priorities and plans to problem-solve together to optimize care.

The assembled QI team should work together to identify gaps in care and transfer processes, specific to the community served. These identified gaps may inform prioritization of the recommendations discussed in this resource kit as required for a community based on data and observed need. Once gaps or opportunities for improvement in processes have been identified, a comprehensive workplan should be outlined and implemented, which must include fundamental education for all team members.

This workplan should include a sustainability plan for involving new team members who join the hospital or community birth settings, and all education should, at minimum, address the scope of practice of all team members as well as communication and collaboration strategies. Finally, all developed protocols, policies, and guidelines (as described in the next subsection, Establish Birth Setting Transfer Protocols, Policies, and Guidelines), should include an education and dissemination plan for all stakeholders, including patients.

Using This Resource Kit to Build a Workplan

Recommended Workplan Component	Resource Kit Section and Subsection
Establishment of workgroup	Readiness: Convene a Collaborative Team
Dissemination of information plan	Readiness: Establish a Collaborative Workplan
Gap analysis	Readiness: Establish a Collaborative Workplan
Goal setting and workplan design	Readiness: Establish a Collaborative Workplan
Design of policy, materials, and evaluation plan	Readiness: Establish Birth Setting Transfer Protocols, Policies, and Guidelines
Initial education plan	Readiness: Care Team Education

Using This Resource Kit to Build a Workplan (Con't)	
Recommended Workplan Component	**Resource Kit Section and Subsection**
Ongoing education plan	Readiness: Care Team Education
Drills and simulation training	Recognition and Prevention: Drills and Simulation
Integration of sustainability	Readiness: Establish a Collaborative Workplan
Integration of equity considerations in each step	Respectful, Equitable, and Supportive Care: Provide Education and Training to Health Care Professionals on Health Equity and Respectful Care
Integration of trauma-informed care considerations in each step	Respectful, Equitable, and Supportive Care: Apply Trauma-Informed Care Concepts for Patients, Their Identified Support Network, and Staff
Dissemination to all stakeholders	Readiness: Establish a Collaborative Workplan
Collection of data	Reporting and Systems Learning: Collect and Monitor Data to Identify Areas for QI
Chart review planning	Reporting and Systems Learning: Perform Multidisciplinary Reviews of Transfers per Established Criteria to Identify Systems Issues
Amendment to processes, policies, and education	Response: Initiate Protocols, Policies, and Guidelines for Safe Transfer of Care when Indicated

Establish Birth Setting Transfer Protocols, Policies, and Guidelines

Developing protocols for transfer can best be accomplished by collaborative QI teams, with the goal of instituting the protocols across all hospitals of transfer involved in the process and including community birth providers. Preparations for birth transfers, including protocols, policies, guidelines, and supporting checklists, help to open lines of communication and contribute to a shared mental model among all providers caring for perinatal patients. These pathways and planning are critical to optimize patient safety and provide high-quality care.

Transfer protocols established by the collaborative QI team for the community should offer guidance on roles, expectations, communication, and management of patient records. Several state and regional QI teams have designed resources that can be adapted or referenced to support planning for transfer of birth settings. A community birth transfer QI team ideally should use frameworks and considerations from existing resources to create and implement agreed-on guidelines or protocols. Clinicians and other stakeholder expert teams may then determine how to adapt the resources to best support their own communities and populations.

The key elements of a safe transfer involve:

- Making the decision to transfer and communicating that decision to facility provider/staff,
- Stabilizing and preparing the patient for the transfer
- Choosing the appropriate mode of transfer (i.e., nonemergency or emergency transfer, involvement of EMS, personnel who should accompany the patient, and equipment and monitoring required during the transfer)
- Providing psychosocial support of the patient and support network
- Documenting and transferring care of the patient at the receiving facility

These key elements should be part of every transfer to prevent adverse events that may severely affect outcomes, including patient and caregiver satisfaction. Preparation is key to ensuring that patients receive safe and respectful care at a time when the complexity of their pregnancy, birth, or postpartum experience has evolved and additional attention may be required to support transfers of care.

Teams can work with internal partners, such as emergency departments and hospital ancillary services, and external partners, such as EMS providers, to establish shared guidelines for the triage and transport of perinatal and neonatal patients. Teams can develop a care process model that provides guidelines to quickly and accurately identify patients who may benefit from transfer to a higher level of care. Additional tools, such as decision trees or process checklists to operationalize care process models may also be developed. As teams create a care process model, they should consider multiple clinical scenarios that may warrant safe stabilization and transfer, such as whether care is urgent or needed simply for access to a higher level of resources. Specific considerations in a model may include criteria for both CNM and physician receiving providers, direction admission versus triage needs, and admission to neonatal intensive care services versus newborn nursery or pediatrics for an infant in need of care. Once care processes and procedures have been developed and tested, teams should translate this information into formal guidelines. For further details on specific components of policies and guidelines (adapted from the Home Birth Summit), see the subsection Initiate Protocols, Policies, and Guidelines for Safe Transfer of Care when Indicated of the **Response** section of this resource kit.

Collections of Resources for Community Birth Transfer and Examples of Transfer Guidelines

➢ **Home Birth Summit**

Since 2009, Home Birth Summits have convened a multidisciplinary group of leaders to address the shared responsibility of the care of pregnant people who plan home births in the United States. The sponsoring organization continues this work via task forces on strategic initiatives that support safe and respectful care, improve interprofessional education, and facilitate research on choice, experience, and outcomes related to chosen place of birth. **See Best Practice Guidelines: Transfer from Planned Home Birth to Hospital for guidelines designed to facilitate the safe and respectful transfer of care.**

Collections of Resources for Community Birth Transfer and Examples of Transfer Guidelines (Con't)

- **Foundation for Health Care Quality:** Smooth Transitions
  Smooth Transitions is a Washington state-based quality improvement program for improving the safety of hospital transfers for planned community-based births. Smooth Transitions incorporates community midwives, hospital providers and staff, doulas, patients, and emergency medical services (EMS) personnel to build a collaborative model of care that centers birthing families. Smooth Transitions provides presentations to hospitals, assists with transfer protocol development, facilitates interdisciplinary meetings focused on transfer and relationship building, and collects qualitative transfer data through online surveys that inform the program. Smooth Transitions provides direct support to hospitals, doulas, EMS personnel, and community midwives participating in the program. The Smooth Transitions staff consults with perinatal quality collaboratives and organizations in other states interested in engaging in community birth transfer improvement.
- Alaska Perinatal Quality Collaborative Birth Transfer Initiative
  The Alaska Perinatal Quality Collaborative created a multidisciplinary advisory committee focused on improving maternal and neonatal transfers from planned community births, including home and birth center births, as Alaska has the highest proportion of community births in the United States. This initiative was adapted with permission from Smooth Transitions. Initiative activities included establishing local transfer committees, developing standardized transfer protocols and forms, and promoting protected case reviews for systems improvements. **See** Best Practice Guidelines for Transfers from Community Births.
- **Maine Center for Disease Control and Prevention:** Best Practice Recommendations for Handoff Communication During Transport from a Home or Freestanding Birth Center To a Hospital Setting
  The Maine Center for Disease Control and Prevention developed this document to "provide a uniform standard to guide communication across settings and professionals caring for women and newborns that are transferred from a home or freestanding birth center to a hospital setting."
- Oregon Community Birth Transfer Partnership
  Building on the work of the Oregon Midwifery Council, a statewide multidisciplinary committee came together to review the culture and process for community-birth-to-hospital transfers in Oregon. Recommendations are summarized in the Oregon Community Birth Transfer Partnership Transfer Improvement Toolkit. The toolkit is designed to improve the transfer process. The Oregon Perinatal Collaborative, the Oregon Midwifery Council, and Comagine Health continue supporting hospital teams, midwives, and birthing individuals and their families in this area.

Collections of Resources for Community Birth Transfer and Examples of Transfer Guidelines (Con't)

- **Utah Women and Newborns Quality Collaborative:** Out of Hospital Births Committee
  The Utah Women and Newborns Quality Collaborative Out of Hospital Birth Committee adapted the Home Birth Summit national best practice guidelines to create a set of Utah Best Practice Guidelines: Transfer to Hospital from Planned Out-of-Hospital Birth. The Utah Best Practice Guidelines reflect existing regional policies and health care provider experiences. The guidelines include content for midwives, hospital providers and staff, hospitals and hospital systems, and doulas.

Provide Education on Best Practices for Transfer of Care

Communication and Collaboration

Collaboration is an essential component of safe and effective perinatal care and includes communication and teamwork. As noted in ACOG's Guidelines for Perinatal Care, "Patient-centered and family-centered care, open communication, and teamwork provide the foundation for optimal patient care and safety."[1] Such care should be the focus of all team members, regardless of qualifications, setting of care provided, or role. When communication is provided in a mutually respectful manner among all disciplines and team members, it may foster psychological safety and encourage team members to give and share information.[2] Respectful discourse and interactions that acknowledge the unique and crucial contributions each team member—including hospital providers, community birth midwives, and patients themselves—brings to each step of patient care is foundational to providing safe, high-quality care.

Curricula such as **TeamSTEPPS** have been developed to promote patient safety and quality in care for a variety of health care teams and settings.[3] These curricula include elements and resources that can be adapted and used in training to support effective team-based communication. Some of the resources described here may not be specifically related to birth setting transfer or community birth, but they include best practices that can be adapted to support essential concepts for provider-to-provider and provider-to-patient interactions.

Resources for Community Birth Transfer and Communication Tools

- **Agency for Healthcare Research and Quality:** TeamSTEPPS
  TeamSTEPPS is a set of teamwork tools intended to improve patient outcomes by improving communication and teamwork skills among health care teams, including patients and family caregivers.
- **Ariadne Labs:** TeamBirth
  TeamBirth supports open communication among patients, their support people, and clinicians during birth. The TeamBirth approach incorporates structured huddles and a shared planning board for shared decision making and is intended to provide individualized respectful care.

Resources for Community Birth Transfer and Communication Tools (Con't)

- **Home Birth Summit:** SBAR [Situation, Background, Assessment, Recommendation] Script for Phone Call Received re: Transfer from Home Birth: This one-page script provides an SBAR-based guide for hospital staff transfer calls from home births.
- **Foundation for Health Care Quality:** Smooth Transitions WA state-based quality improvement program enhancing the safety of hospital transfers from home or freestanding birth centers. Scripted protocol guides that can be modified:
  - Template Protocol: Hospital Transfer from Planned Community Birth
  - Template Protocol: Early Discharge for the Newborn
  - 911 Protocol for Community Midwives
- **American Association of Birth Centers Toolkit:** Coordination + Collaboration with EMS for Safe, Timely Transfer: This toolkit is designed to help facilitate safe emergency transport between birth centers, collaborating hospitals, and local EMS systems through active engagement and teamwork. The toolkit includes recorded webinars, learning modules, templates, example documents, and more.
- **Primary Maternity Care:** Step Up Together Action Collaborative for Birth Centers and Their Partner Hospitals The Step Up Together Action Collaborative is designed for birth center and hospital dyads that are invested in improving their collaboration, emergency preparedness, and transfer process. The program provides the information and resources necessary for participants to plan, conduct, and debrief a full transfer drill that begins at the birth center, travels by emergency transport, and ends in the hospital.

Care Team Education

The following sections identify aspects of needed education for hospital providers and community-based midwives. Shared learning of these concepts is essential to success in any QI initiative and may build trust and confidence in team members. Knowledge sharing within and among teams creates a consistent mental model for all patient care. Ideally, education and learning take place in shared educational sessions.

To facilitate transfer of care, all team members should receive education on the following content:

- The scope of practice and role of each member of the EMS, hospital, and community birth teams involved in the transfer process,
- Most common reasons or conditions precipitating birth setting transfer,
- Recognition of and response to conditions that indicate need for transfer to setting with appropriate level of care,
- Best practices for clear communication among all team members, including use of situation, background, assessment, and recommendation (SBAR) technique or other formal methods for providing essential information in the transfer process,
- Strategies for successful collaboration as a team, with patients and their identified support network included as expert team members.

All team members, regardless of practice setting, should be able to work together cohesively during community birth transfers. To work collaboratively, each health care provider should have a clear understanding of the practice scope and standards of the other providers involved, the best practices for community birth transfers, and the levels of care available in each setting the patient moves through during a transfer. Steps should be taken to ensure that hospital-based and community-based care providers receive ongoing education and that new team members receive education on processes and policies to ensure the sustainability of QI practices.

Examples of Community Midwife Practice Standards

- **Midwives Association of Washington State (MAWS)**: This webpage includes a downloadable copy of the MAWS Standards for the Practice of Midwifery published in 2002.
- **Oregon Midwifery Council (OMC):** This guideline provides a review of OMC community practice standards and best practice guidelines.
- **Best Practice Guidelines: Transfer from Planned Home Birth to Hospital | Home Birth Summit:** This statement from the Collaboration Task Force of the Home Birth Consensus Summit provides practice guidelines for transfer from planned home birth to hospital.

Examples of Midwifery Integration

- **California Maternal Quality Care Collaborative: Quality Improvement Webinar on Midwifery Integration:** This webinar recording features panelists discussing the meaning and importance of midwifery integration for quality improvement in perinatal care.
- **American College of Obstetricians and Gynecologists: Collaboration in Practice Implementing Team-Based Care:** This task force report provides a framework across all disciplines and specialties, to develop team-based care.

Example of Provider Education

- **Journal of Midwifery & Women's Health: Catalyzing Collaboration Among Interprofessional Birth Transfer Teams Through Simulation The Utah Women and Newborns Quality Collaborative and LIFT Simulation Design Lab** developed and piloted an interprofessional birth transfer simulation training. This paper examines the feasibility and effectiveness of interprofessional birth transfer training.

Examples of Provider Education (Con't)

- **HiveCE: Transfer Tools for Midwives, EMS, and Hospital Providers**
  This online interprofessional education encompasses methods for improving home birth- and birth-center-to-hospital transfers, communication skills, clinical best practices, simulated scenarios, and more to improve transfer processes.
  Note: Paid resource, discounts available

- **Oregon EMS and Trauma Systems Webinars**
  These free webinars are offered by Oregon Emergency Medical Services, Oregon Health Authority, and the Oregon Midwifery Council. Webinar topics include **Working with Community Midwives for Smooth Home Birth Transfers** **and** **Improving Outcomes for Prehospital Labor and Delivery.**

- **American Association of Birth Centers: Birth Center Onboarding Training—Providers**
  (See the clinical training module Birth Center Transfer and Transport: Optimal Practice for Safe and Satisfying Transitions of Care) This training module provides birth center providers information on types of transfer, the importance of collaboration with EMS and hospital-based providers, and best practices for continuous transport quality improvement. It is intended for clinical and nonclinical birth center team members.
  Note: Paid resource

- **Primary Maternity Care: A Birth Center Primer for Hospital Leaders: Achieving Seamless Collaboration and Advancing Equity Through Community-Based Care**
  This six-part webinar series is intended to help hospital leaders develop a strategy to strengthen their relationships with freestanding birth centers in their communities or to participate in establishing a center. Topics include assessing readiness and centering equity in the hospital's birth center strategy, developing eligibility criteria and collaborative care guidelines, designing transport workflows, maximizing collaboration across facilities, and more.
  - **Session 1:** Assessing Readiness and Centering Equity in Your Hospital's Birth Center Strategy
  - **Session 2:** Developing Eligibility Criteria and Collaborative Care Guidelines

- **Foundation for Health Care Quality: Smooth Transitions**
  - **Infographic: Licensed Midwifery in Washington State:** This 2-page infographic introduces the role of Licensed Midwives (LMs) in Washington State to those who are not familiar with LMs.
  - **Scope of Practice for Licensed Midwives in Washington State:** This document details the scope of practice for Licensed Midwives in Washington State.
  - **Smooth Transitions Template Protocol: Hospital Transfer from Planned Community Birth:** This customizable protocol template can be tailored by hospitals to clarify the transfer process.
  - **Perinatal Transfer Committee Initial Meeting—Sample Agenda:** This sample agenda and accompanying slide deck (found under "Perinatal Transfer Committee Meeting Tools") provide examples of items that could be discussed at the first meeting of a newly-formed Perinatal Transfer Committee.

Example of Provider Education (Con't)

- **Smooth Transitions Overview Video:** This video provides an overview of the Smooth Transitions program components including co-creation of transfer protocols and establishment of a Perinatal Transfer Committee.
- **Oregon Community Birth Transfer Partnership**
  Tips for Welcoming Community Birth Transfers (p. 34, Transfer Improvement Toolkit): This list of tips provides guidance for fostering a welcoming environment for community birth transfers in hospital settings.
- **Alaska Perinatal Quality Collaborative Birth Transfer Initiative:**
  Alaska Birth Transfer Guidelines Template (Downloadable from resource list)
  This downloadable template can be customized by hospitals to clarify the details of the community birth transfer process.
- **Primary Maternity Care: Hospital Guide to Integrating the Freestanding Birth Center:**
  This guide includes a Birth Center Stakeholder Planning Map, a tool used to systematically assess the potential interests and concerns of birth center stakeholders.

Patient Education

Informed decision making is built on transparency and education. People giving birth have the right to respectful, safe, and seamless consultation, referral, transport, and transfer of care when necessary. Interprofessional dialogue ensures that those receiving care are prioritized and fully engaged with a clear understanding of the risks and benefits associated with decisions. It is imperative that community and hospital providers provide education on processes in place in the event of a hospital transfer.[4]

Preparing individuals to give birth in the community setting should include providing information about hospital care and procedures that may be necessary. Creating a birth plan with hospital preferences, if a transfer occurs, can assist families in making informed decisions about their care processes. Sharing key aspects of the transfer process before labor can aid in reducing concerns. It may be helpful to provide an overview of the transfer process (including the potential reasons for transfer and modes of transfer), communication protocols in the hospital, roles of family members and support people during the transfer process, and role and scope of the community birth midwives after transfer to the hospital.[5] Education should include how care plan updates will occur and plans for care after discharge from the hospital.[5]

Financial considerations related to possible hospital transfer should be discussed, particularly if the cost of transfer may present a barrier to the patient receiving needed care.

Familiarity with the hospital environment might reduce a patient's anxiety about a potential transfer. Patients may be encouraged to take a tour of the hospital, virtually or in person, that would most likely be a facility of transfer if needed either in labor or postpartum. Patients may also be provided with documents developed by the hospital that explain the care it offers. The patient's birth preference documents should include a plan specifically for hospital transfer. Reviewing this plan together provides another opportunity to check in with patients about any concerns about the possibility of transfer.

Many patients use online tools to develop their birth preferences. These plans may include language about routine hospital-based interventions, including induction, augmentation, epidural use, cesarean birth, and other interventions that patients might have been hoping to avoid by planning to give birth at home or in a birth center. During education and discussions with patients, it is important to highlight that these interventions may be appropriate and even desired in the event of a transfer.

Any discussions with patients, whether involving community birth midwives or hospital care team members, should emphasize that **transferring to the hospital is *not* a failure.** Transfer in any type of healthcare is about accessing appropriate tools and levels of care, beyond what would be available otherwise, at the right time to optimize quality and safety of care.

When the patient nears 37 weeks of gestation, community birth providers may consider the following:

- Recommend that patients pack a hospital bag in case a transfer is indicated. Transfers can be hectic, even if they are not emergencies, and having one less thing to do at that moment may be helpful.
- Review in detail the plan for transfer and emergency situations.
- Review the planned birth location to evaluate EMS accessibility. This topic has the potential to be stressful, so discussion may provide an opportunity to convey how well prepared the providers are to handle transfer events.
- Clarify roles and responsibilities in the event of a transfer, including receiving provider communication, how records and information will be shared with the hospital provider and staff, whether members of the community birth team will stay at the hospital, and what role the community birth team will play following transfer.
- Discuss the course of care after discharge from a hospital if admission is needed.

The resources below offer guidance to support these sometimes difficult, yet important conversations with patients. Some are tools to weave in and share during these discussions, while others describe larger QI programs that target this work.

Examples of Practice Preparations for Community Birth Transfer

- **Midwives' Association of Washington State:** Indications for Discussion, Consultation, and Transfer of Care in Home or Birth Center Midwifery Practice
  This document can be used as a screening tool to distinguish between low-risk and higher-risk patients. It aims to enhance safety and promote midwives' accountability to their patients.
- Oregon Community Birth Transfer Partnership
  - **Sample Community Midwife Hospital Transfer Plan (p. 41, Transfer Improvement Toolkit)** This transfer plan can be used to inform patients about what emergency and non-emergency transports are and the partnering hospitals.
  - **Sample Hospital Transfer Worksheet (p. 42, Transfer Improvement Toolkit)** This worksheet can be filled out by patients to communicate questions and concerns about birth transfers and their preferred hospital if a transfer becomes necessary.

Examples of Practice Preparations for Community Birth Transfer (Con't)

- **Maine Center for Disease Control and Prevention:** Best Practice Recommendations for Handoff Communication During Transport from a Home or Freestanding Birth Center to a Hospital Setting
  - **Role of the Mother (p. 7):** This guidance provides recommendations for the role of the patient in the transfer process.
  - **Role of the Transferring Midwife or Physician (p. 8):** This guidance provides recommendations for the role of the transferring midwife or physician in the transfer process.
- **Foundation for Health Care Quality:** Smooth Transitions Preparing Clients for Hospital Transfers: A Guide for Community Midwives: This guide reviews considerations for community midwives before, during, and after a transfer.
- **Utah Women and Newborns Quality Collaborative Out of Hospital Birth Committee**
  - Infographic **(types of midwives):** This infographic provides an overview of the types of midwives in Utah.
  - Infographic **(doulas):** This infographic provides an overview of the role of doulas in the United States.
  - Transfer Guideline Template: This template can be customized to provide details on the transfer process and post-transfer communication needs.

References

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[3] Agency for Healthcare Research and Quality. TeamSTEPPS. Accessed March 27, 2024. https://www.ahrq.gov/teamstepps-program/index.html

[4] Lothian J. In This Issue—Making Home Birth Even Safer for Mothers and Babies. J Perinat Educ. 2017;26(1):3-6. doi: 10.1891/1058-1243.26.1.3

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Recognition and Prevention

Drills and Simulation

A major predictor in the safety and quality of a transfer is how well health care providers, including community birth, in-hospital, and EMS providers, can collaborate and communicate.[1, 2] Drills and simulations help reinforce team culture and improve communication among all members of the care team. As stated by ACOG, "Effective drills may lead to improved standardization of response, health care provider satisfaction, and patient outcomes."[3]

Multidisciplinary drills provide an opportunity for a team to build trust, rapport, and a shared mental model in a safe environment. Simulation that extends outside of a hospital birth setting to community settings may also allow for testing of processes and planned procedures and adjustments to those plans, based on information gathered. In situ drills, which take place in actual settings of care—for example, transfer from a freestanding birth center to a hospital—allow testing of facilities and equipment such as ramps, stretchers, and doorways outside of an emergency.[4]

Planned drills and simulation should be built into the QI teams' workplan to improve safety and quality in community birth transfer (as discussed in the **Readiness** section). Clinical scenarios should be realistic and aligned with common community transfer needs. Representation should be present for all of those that may participate in a community birth transfer, including but not limited to the following people:

- Hospital care teams, including certified nurse-midwife, physician, and nursing team members
- Hospital emergency medicine, anesthesia, or critical care team members
- Other hospital units that may support a transfer, including respiratory therapy, blood bank and laboratory services, pediatric, and neonatology team members
- A variety of midwives and community birth providers, ideally from multiple practices and disciplines
- EMS and first responders, including emergency services dispatchers
- Simulated patients and support network, such as partners, family, or doula
- People with lived expertise in advisory roles

Shared debriefing following each session is essential to establish what went well and what would benefit from improvement, as well as to assist in planning future shared interprofessional learning activities. Debriefs should model and follow practices used after actual transfers. See the **Reporting and Systems** Learning section for more details on debriefing after drills.

Resources for Birth Transfer Simulations

- **Journal for Midwifery & Woman's Health:** Interprofessional Communication and Collaboration During Emergent Birth Center Transfers: A Quality Improvement Project. Report of a quality improvement project including simulation with tables including phases of project and education sessions, using a plan-to-do-study-act model.

Resources for Birth Transfer Simulations (Con't)

- **Journal for Midwifery & Woman's Health:** Catalyzing Collaboration Among Interprofessional Birth Transfer Teams Through Simulation: Describes a pilot of an interprofessional simulation scenarios, as well as photos of an in process simulation.
- **American College of Obstetricians and Gynecologists: Commitee Opinion No. 590,** Preparing for Clinical Emergencies in Obstetrics and Gynecology.

Provide Patient Education on Signs and Symptoms During Pregnancy and Postpartum and When to Seek Care

Community birth midwives routinely assess clinical and social risk factors at the intake visit and continuously throughout prenatal, birth, and postpartum/newborn care to determine appropriateness for community birth care. Communicating about risk status with a pregnant person includes education about the dynamic nature of risk and the importance of communication about emerging symptoms that may require obstetric consultation or transfer to a higher level of care. As in any setting, patients need clear education about early warning signs of serious and potentially life-threatening complications. In community birth models, this education is frequently provided as part of standard prenatal and postpartum information packets, through patient portals and other digital tools, and in childbirth and postpartum/newborn classes that are commonly integrated into prenatal care offerings.

Education on signs and symptoms can indicate whether concerns may be addressed by community birth providers or warrant consultation, transfer, or referral to hospital-level or physician specialist care. Education opportunities should be extended to the pregnant or postpartum person's support network, which may include partners, family, friends, and doulas. Patient education materials are available online and in multiple languages; they can be provided to patients or posted in offices and birth center areas.

Examples of Patient Education Materials for Urgent Signs and Symptoms During Pregnancy and Postpartum

Patient Education Material	Costs Associated with Use	Available in Languages Other than English
Centers for Disease Control and Prevention: HEAR HER Campaign	No	Yes (multiple)
Association of Women's Health, Obstetric and Neonatal Nurses: POST-BIRTH Warning Signs	Yes	Yes (multiple)
AIM: Urgent Maternal Warning Signs	No	Yes (multiple)
National Maternal Mental Health Hotline	No	Yes (Spanish and English)

References

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Response

Communication and Collaboration

Optimizing Professional Communication

Building a culture of safety through civility and respect among care providers is a critical component of QI in all health care. In the case of community birth transfer is needed, a culture of safety encompasses all who care for the patient, regardless of location. Every team member should feel comfortable speaking up to optimize safe, respectful, and high-quality care. Setting expectations for appropriate behavior and communication and modeling such behavior should be a priority of the QI team working to improve community birth transfer.

Disrespectful interactions present a key risk to quality of care, are unprofessional, and are considered a form of disruptive behavior that undermines teamwork and the culture of safety; they also may contribute to patient safety events. This type of disruptive behavior is a choice. It may be considered an at-risk behavior and should be evaluated using the "just culture" system of accountability.[1] A just culture recognizes that people can make mistakes and acknowledges that competent professionals can develop unhealthy norms, such as taking shortcuts and routinely violating established rules. A just culture, however, has zero tolerance for reckless behavior,[2] including disrespectful or derisive communication between care team members, regardless of credentials or practice setting.

A culture of safety draws on several principles, such as a shared purpose, psychological safety, a culture of trust, and reflection. These concepts may be established, supported, and reinforced by shared learning, bidirectional communication, and building trust over time; plans to support and augment these concepts in practice should be explicitly integrated into all aspects of a community birth transfer QI workplan. Addressing entrenched cultural issues can seem an insurmountable hurdle but can be supported by using standard tools that reframe how all team members communicate and recontextualize their relationships with each other. Examples include establishing rules of engagement that all providers and clinicians commit to adhering to; consistently using standard communication tools, such as SBAR or projects **such as TeamBirth**; and implementing a structured process for patient care transitions with community birth transfer.

All individuals who are providing care should commit to professionalism and civility in interactions and in how care is provided in any setting or when another provider's care is discussed with patients and their support network to optimize quality and safety of care.

Optimizing Patient Communication

Excellent clinician-patient communication is essential in providing safe, high-quality, and respectful patient care.[3] As an expert on their own lived experience, any person receiving care should be included as a valued member of the health care team at each step of care provided, and this includes the birth setting transfer process. This inclusion requires ongoing, transparent, respectful, and appropriate communication with the patient and their support team.[4]

A patient's chosen support network may include partners, family members, and other trusted individuals selected to be present for the labor and/or birth experience. While participating in the birth experience is important for many partners,[5] some describe feeling unheard or sidelined, especially during shifts in location of planned care.[6] Providing patient-centered care involves the inclusion of partners and support persons in ongoing communication as the patient desires.[7]

Patient autonomy and informed decision making, as discussed in the **Introduction**, requires that patients have high-quality and accurate information.

A community birth transfer for any reason represents a shift in planned care and care complexity. The transfer process represents a change in the care plan that can cause anxiety and heightened concerns and may activate a trauma response for patients, partners, and family members who have a history of trauma (See the **Respectful, Equitable, and Supportive Care** section for more information.) Hospital providers and staff can support an ongoing plan of care that incorporates the values, beliefs, and preferences of the person giving birth by being welcoming, communicating clearly, and providing ongoing patient and family education. This education and care should be provided in tandem with the community birth provider as desired by the patient.

Clear, concise information that is free of bias or judgment is foundational to establishing an environment where high-quality care may be provided. Team members, both in hospital and community settings, should take explicit care to avoid conveying a sense of undermining, condescending, or disrespect for each other in their communication with the patient and their designated supports.

A specific plan should be outlined by the QI team and agreed on by care providers that spells out who will provide the patient with explanation, debriefing, and space to process their birth and transfer experience after delivery and how these steps will be accomplished. This critical debriefing, specifically focused on the patient's experience and the clinical context, and similar interventions have been shown to reduce or prevent posttraumatic stress symptoms and posttraumatic stress disorder in postpartum women.[8]

Conduct Huddles and Post-Event Debriefs to Identify Successes, Opportunities for Improvement, and Action Planning for Future Events

Huddles, debriefing, and action planning during and after community-birth-to-hospital transfer can provide valuable insights for health care team members to improve processes and perinatal outcomes, as well as foster situational awareness and collaborative working relationships.

Huddles

Event or occurrence huddles are ad hoc, brief meetings that occur in real time when there is a change in patient status, change in resources for care, or other acute topics that require team awareness and planning. This type of pause in care with shared discussion allows for understanding of changing events and enhances the team's ability to rapidly plan for actual or potential changing needs in care. A team huddle, designed to reinforce plans already in place and to assess the need to adjust the plan, also may be used to review situational awareness and to troubleshoot and revise the current plan of action, if needed. Huddles specific to events or occurrences may include all or just a few team members and can be called by any team member.

The team should include all those providing and planning for care, including the transferring community birth midwife whenever possible. If a community midwife is no longer present and their participation is deemed important, they may be included in huddles via phone or meeting platforms. A community midwife directory is useful to encourage open communication with the community midwife and hospital providers and staff.

The person giving birth and their designated support team, including partner, doula, or others, should be included in and inform this type of huddle as a plan of care is evolving.[11]

Huddles Example

- **Tampa General Hospital: Pre-Cesarean Huddle Form:** This huddle form provides an example of a communication tool which can be used to guide and document a huddle.

Huddles Resources

- **Washington State Hospital Association: Guide to Safety Huddles:** This guide provides practical recommendations for conducting huddles.
- **Smooth Transitions Team Birth Collaboration Resources:** These resources include guides for midwives and doulas on TeamBirth processes including regular huddles.

Debriefs

The debriefing process is an important facet of a culture of safety. Debriefs allow teams to identify successes and operational difficulties, provide real-time feedback, and conduct short-term planning for follow-up processes. Ideally, a debriefing immediately follows an episode of care and involves a short, concise discussion of what went well and what could be improved in the future. At times, it may be helpful for a team to use a guided debriefing form that is not part of the patient's medical chart, but instead is used by the broader QI team to address any needs for future planning.

Before a community birth midwife leaves the hospital, a debrief with the receiving provider and nursing staff may be helpful, particularly if any of the interactions during the transfer have been stressful. This is not the time to give feedback; rather, it is an opportunity to build a mutually respectful relationship by expressing gratitude for any aspect of the transfer that went well.

Debriefs Resources

- **California Maternal Quality Care Collaborative: Sample Perinatal Safety Debrief Form** This example debrief form provides an example of a communication tool which can be used for the debriefing process.

Debriefs Resources (Con't)

- **Florida Perinatal Quality Collaborative:** Debriefing Following a Severe Incident in Pregnancy This one-page guide provides an overview of debriefing, it's practical application, and recommendations.
- **Nebraska Coalition for Patient Safety:** Patient Safety Improvement Tools: Debriefs This webpage includes a compilation of resources and examples that support the debriefing process including webinar recordings, templates, and forms.
- **Texas Children's Hospital:** Debriefing Clinical Events: Improving Team Communication and Collaboration This slide deck includes recommendations for important elements of a debrief.

Action Planning

Following a patient care episode and debrief, steps should be taken to address identified gaps in care, processes, and equipment or supplies. This effort should include all members of the care team, including the community birth provider, to reinforce that patient safety and high-quality care are each team member's responsibility. Facilities and QI team members can design a system as part of the community birth transfer workplan to allow team members to document issues and review processes discussed during debriefs. Each team should identify a formal pathway to share knowledge gained from the event with leadership and staff. Teams should determine who is responsible for improvements as part of action planning.

Action Planning Resources

- **Agency for Healthcare Research and Quality (AHRQ):** Action Plan for the AHRQ Surveys on Patient Safety Culture This action plan template can be customized to define and guide the steps to be taken for QI.

Use Standardized Communication Practices to Facilitate Transfer of Care

The American College of Obstetricians and Gynecologists states, "In the era of collaborative care, effective clinician-to-clinician communication is important to facilitate continuity of care, eliminate preventable errors, and provide a safe patient environment."[12]

In the event of transfer, a midwife should remain with the person they are caring for, and direct, provider-to-provider communication should occur, including ongoing conversation about care management. Provider conversations in this instance may include community birth provider to EMS, as well as EMS with community birth provider to hospital team to optimize continuity of care. Whenever possible, communication should be initiated before arriving at the hospital to allow the receiving facility to prepare for the transfer.

On arrival of the patient to a hospital for care, face-to-face bedside communication among providers, nursing staff, the patient, and the patient's identified support network should occur according to established transfer protocols, as discussed in in the **Readiness** section.

Accurate communication of information about a patient from one member of the health care team to another is a critical element of patient care and safety. This is particularly true during a transfer of care to another clinician. In the era of collaborative care, effective clinician-to-clinician communication, including community birth providers and EMS, is essential to facilitate continuity of care, eliminate preventable errors, and provide a safe patient environment.

Any transfer of care should include an opportunity for all involved to ask questions about, clarify, and confirm the information being transmitted. As part of its standard for provision of care, treatment, and services, The Joint Commission emphasizes that the "process for hand-off communication provides for the opportunity for discussion between the giver and the receiver of patient information."[13] Ineffective organization of the information by the sender and lack of attention by the receiver are two significant barriers to the effective transfer of vital information. Structured forms of communication should be considered, such as use of templates and SBAR.

Medical Record Access

When responsibility of caring for a patient shifts from one clinician to another, the transfer of patient information and historical knowledge of care may be lost or disrupted. The most effective sharing of patient information includes both verbal and written components. Prenatal and labor records (copies or originals) from the community birth practice should accompany the patient to the hospital, including all including all laboratory and ultrasound results, and referral and outcomes of consultation(s). This sharing of information should be reciprocal; community birth providers should have access to the patient's hospital chart after discharge for ongoing care by the patient's provider of choice.

Examples of Communication Practices to Facilitate Safe Transfer of Care

- **Maine Center for Disease Control and Prevention:** Best Practice Recommendations for Handoff Communication During Transport from a Home or Freestanding Birth Center To a Hospital Setting
  - Brief SBAR [Situation, Background, Assessment, Recommendation] Script for Phone Call Initiating Transport by EMS (p. 11-13)
  - Brief SBAR Form for Recording Phone Call to Hospital regarding Transport (for nurse receiving the transfer call, p. 14)
- **Foundation for Health Care Quality: Smooth Transitions:** 911 Protocol for Community Midwives**:** This protocol provides guidance for community midwives calling 911 to initiate a transfer of care.
- **Home Birth Summit**
  - SBAR Script for Phone Call Received re: Transfer from Home Birth**:** This one-page script provides an SBAR-based guide for hospital staff transfer calls from home births.
  - Transfer Guidelines Model Forms **(newborn and maternal):** These downloadable forms can be used to support safe and respectful transfers.

Examples of Communication Practices to Facilitate Safe Transfer of Care (Con't)

- **Utah Women and Newborns Quality Collaborative:** Utah Best Practice Guidelines: Transfer to Hospital from Planned Out-of-Hospital Birth
  This guide provides recommendations for best practices before, during, and after transfer (pp. 2, 4, 5, and 7)
- Oregon Community Birth Transfer Partnership
  Tips for Welcoming Community Birth Transfers (Transfer Improvement Toolkit, p. 34): This list of tips provides guidance for fostering a welcoming environment for community birth transfers in hospital settings.

Initiate Protocols, Policies, and Guidelines for Safe Transfer of Care When Indicated

As discussed in the **Readiness** section of this resource kit, preparing for birth transfers—for example, by adopting protocols, policies, guidelines, and supporting checklists—contributes to opening lines of communication and creating a shared mental model among all providers caring for perinatal patients.

Timely transfer and, in an emergency, stabilization, are key to providing risk-appropriate care and ultimately reducing preventable morbidity and mortality.[14] Teams without formal obstetric services should establish feasible plans and pathways for patient stabilization and transport to higher levels of care, regardless of transfer urgency.

Through comprehensive discussion among multidisciplinary teams of delegates to two national Home Birth Consensus Summits, the following components of model best practices were identified[15] These components may guide development and enactment of protocols for birth setting transfer by community birth QI teams:

Home Birth Consensus Summit Model Practices for the Community Birth Provider

- In the prenatal period, provide information about hospital care and procedures that may be necessary and documents that a plan has been made for hospital transfer should the need arise.
- Assess patient status throughout the maternity care cycle to determine if a transfer will be necessary.
- The midwife will notify the receiving provider or hospital of the incoming transfer, reason for transfer, brief relevant clinical history, planned mode of transport, and expected time of arrival.
- Continue to provide routine or urgent care enroute in coordination with any emergency services personnel and address the psychosocial needs of the patient during the change of birth setting.
- Upon arrival at the hospital, provide a verbal report, including details on current health status and need for urgent care. Provide a legible copy of relevant prenatal and labor medical records.

- The community birth provider may continue in a primary role as appropriate to their scope of practice and privileges at the hospital. Otherwise, the community birth provider will transfer clinical responsibility to the hospital provider.
- Promote good communication by ensuring patient understanding of the hospital provider's plan of care and that the hospital provider understands the patient's need for information regarding care options.
- As desired by the patient, the community birth provider may remain to provide continuity and support.

Home Birth Consensus Summit Model Practices for the Hospital Provider and Staff

- Accepting hospital team members will be sensitive to the psychosocial needs of the patient that result from the change of birth setting and provide trauma-informed communication and care.
- Accepting hospital team members will communicate directly with the community birth provider to obtain clinical information in addition to the information provided by the patient.
- Timely access to maternity and newborn care providers may be best accomplished by direct admission to the labor and delivery or pediatric unit.
- Whenever possible, the maternal-infant dyad is kept together during the transfer and after admission to the hospital; care to avoid maternal-infant separation should be explicitly centered.
- Accepting hospital team members participate in informed decision-making process with the patient to create an ongoing plan of care that incorporates the values, beliefs, and preferences of the person giving birth or who has given birth.
- As desired by the patient, hospital personnel will accommodate the presence of the community birth provider as well as the patient's primary support person during assessments and procedures.
- Accepting hospital provider and the community birth provider coordinate follow-up care for the pregnant or postpartum person and newborn, and care may revert to the community birth provider upon discharge.
- Relevant medical records, such as a discharge summary, are sent to the referring community birth provider.

Examples of Transfer Protocol Template

➢ **Foundation for Health Care Quality:** Smooth Transitions
Modifiable Templates:

- **Smooth Transitions Template Protocol: Hospital Transfer from Planned Community Birth:** This customizable protocol template can be tailored by hospitals to clarify the transfer process.
- **Early Discharge for the Newborn—Template:** This template includes recommendations of criteria to assess well newborns for possible early discharge from the hospital and an informed consent agreement for use with parents.

Examples of Transfer Protocol Template (Con't)

- Oregon Community Birth Transfer Partnership
  - **Sample Community Midwife Hospital Transfer Plan (p. 41, Transfer Improvement Toolkit):** This transfer plan can be used to inform patients about what emergency and non-emergency transports are and the partnering hospitals.
  - **Sample Hospital Transfer Worksheet (p. 42, Transfer Improvement Toolkit):** This worksheet can be filled out by patients to communicate questions and concerns about birth transfers and their preferred hospital if a transfer becomes necessary.
- **Home Birth Summit: Transfer Guidelines Model Forms Transfer from Planned Home Birth to Hospital (Completed form required to obtain PDF):** These downloadable forms can be used to support safe and respectful transfers.

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Reporting and Systems Learning

Communication and Collaboration

When a transfer from a planned community birth occurs, many different people are involved in patient care. The coordination and communication among these groups of health care team members can be complicated and challenging, even with established protocols and healthy, collaborative relationships in place. Quality improvement efforts that focus on these types of complex interactions should have mechanisms for providing and receiving feedback that capture learning for care.

As noted in the **Response** section, using a just culture approach may support all QI project aspects and a culture of safety in care. Having standing meetings (for instance, quarterly) to review transfers and unusual events may reduce the sense among participants that a review is being prompted by concerns about individual performance and may cultivate a culture of continuous QI. Sentinel events may warrant more prompt review. Regular joint quality meetings that include community birth providers are also important opportunities for building trusting relationships, offering general program updates, reviewing practice statistics and patient survey data, and engaging in other collaborations that can build rapport between hospital-based and community-based providers. Such camaraderie among colleagues can be helpful in times of stressful transfers.

Perform Multidisciplinary Reviews of Transfers per Established Criteria to Identify Systems Issues

All transfers, including routine and nonurgent transfers, present potential opportunities for team and system learning and improvement. Unexpected or sentinel events are particularly important to review. In birth centers, regular review of transfers and reporting of sentinel events to the Commission for the Accreditation of Birth Centers are required activities for accreditation. Some states have similar requirements for all licensed community birth midwives and facilities. These differ from huddles and debriefs, which are brief, structured meetings to immediately plan for care while care is being provided and then to assess the outcome of the plan of care as a team immediately following the event (see the **Recognition and Prevention** section).

To effectively identify learning and improvement opportunities, multidisciplinary teams need mechanisms for structured review that are supportive and nonpunitive for all participants, confidential, and protected from litigation. Some state and regional perinatal quality collaboratives have established models for protected review. Many of the QI tools and resources developed for community birth transfer and featured in this resource kit stem from these initiatives and have been disseminated nationally and internationally, improving the opportunity for safety in community birth broadly.

Inpatient care services should hold regularly scheduled QI case reviews of all types of care provided and should incorporate hospital transfers from community birth settings among cases to be discussed regularly. As part of a workplan, teams seeking to optimize quality and safety of care in community birth should identify quality "triggers" or specific criteria that identify a need for collaborative community birth transfer chart review, such as instances of severe maternal morbidity or mortality or poor neonatal outcomes.

Key stakeholders working in community birth settings, particularly the community birth provider(s) who provided care and clinical champions within the hospital system who have an understanding of community birth, should partner in the planning for review of these cases and should play a key role in the presentation and discussion. Identified gaps and opportunities for improvement should be reported back to the QI team to inform creation of feasible next steps in the community birth transfer process.

Collect and Monitor Data to Identify Areas for QI

According to the National Academies of Sciences, Engineering, and Medicine, the lack of concurrent data collection for births in hospitals and community settings is a major limitation to the ability to compare outcomes. These comparative data are critical to understanding and improving maternal and newborn care and birth outcomes in all settings.

Multidisciplinary perinatal quality collaboratives that include community birth providers and community birth settings can play an important role in data collection and standardization, development of performance measures, safety, resource use, and person-reported experience and outcome measures applicable across all birth settings. Critically, they also enhance opportunities for strengthening interprofessional relationships, promoting interdisciplinary shared learning and teaching, and developing a more integrated and effective system.[1] Full engagement across providers and settings also allows for information exchange about optimal practice approaches and shared understanding of care escalation (as outlined in AIM's patient safety bundles when recognition and response are necessary) across hospital and community birth settings.

Because more than 98% of the births in the United States occur in hospitals, perinatal quality collaboratives tend to focus predominantly on improving hospital-based care. However, excluding planned community births from quality collaboratives provides an incomplete picture of birth in the United States. It also limits the opportunities to promote greater integration of maternity care across all settings and providers, expand care options for families, and generate much-needed QI across the full spectrum of care.[2]

A QI team may wish to collect data that show trends in the challenges to and facilitators of transfers; data collection should focus on surveillance that contributes to process improvement and population health. Data may be collected through routine chart audits or abstraction or tracking metrics determined by the QI team. The data collection process should identify baseline data, ongoing processes, and data over the long term to monitor sustained improvements. Planning for this type of data monitoring should be established formally in the QI team workplan at the inception of the project and before any interventions are started.

Teams engaging in QI for community birth transfer across regions or states should consider what may be required to collect ongoing data when planning for QI. Efforts to facilitate data collection and improve the quality of data collected may consider specific actions, such as modifying birth certificate data collection forms to better capture transfers from planned community births or other data required for process improvement planning and monitoring. These components may be part of the QI team workplan structure when it is established.

Existing Current Models for Data Collection for Community Birth and Community Birth Hospital Transfers

- Annual data reports from hospitals participating in a community birth transfer improvement program. Washington and Oregon have model annual data report forms that are publicly available.
  - Smooth Transitions Annual Evaluation Form for Facilities
  - Community Birth Transfer Partnership Annual Audit Form (page 37 of toolkit)
  - Smooth Transitions Annual Review Form for Community Midwives
- Data collection through birth certificate questions that identify planned versus unplanned community births, attended versus unattended community births, provider type at all community births, and planned community births that involved a hospital transfer. Oregon is the model birth certificate that collects this information.
  - Oregon Planned Place of Birth Data Dashboard
- State, PQC-based, or national database to collect community birth and community birth transfer data. The Foundation for Health Care Quality in Washington state has developed the Community Birth Data Registry which is a model for this type of database. The registry consists of detailed, chart-abstracted data about the care given during prenatal care, labor, birth and the postpartum period as the basis for analysis, benchmarking, and improvement.
  - Foundation for Health Care Quality Community Birth Data Registry
- National data registry launched by Midwives Alliance of North America to collect comprehensive data on birth and associated perinatal care outcomes.
  - Midwives Alliance of North America MANA Stats Data Registry

Resources for Protected Transfer Review

- **Obstetrics & Gynecology:** Multistate Collaboration to Confidentially Review Unanticipated Perinatal Outcomes
  - Process and outcomes of the Northern New England Perinatal Quality Improvement Network's Confidential Review and Improvement Board.
- **Midwives Association of Washington State:** Quality Management Program: Incident and Peer Review
- **Primary Maternity Care: A Birth Center Primer for Hospital Leaders:** Achieving Seamless Collaboration and Advancing Equity Through Community-Based Care
  - Session 5: Preventing and Learning from Sentinel Events (continuing education webinar)

Resources for Protected Transfer Review (Con't)

- Smooth Transitions
  - Perinatal Transfer Committee Initial Meeting—Sample Agenda
  - Smooth Transitions Reviews: Multi-disciplinary, Protected Case Reviews (Intention is for these reviews to be educative, not punitive. Internal reviews take place during regularly held Perinatal Transfer Committee meetings; external, 3rd party reviews of cases brought forward by individual hospital providers/staff, community midwives, or patients; data from the CBDR/OB COAP/WSHA may also trigger an external review. Data is de-identified; review committee notes any trends and looks for opportunities for improvement. Recommendations of the committee are shared with all parties involved in the case.)
- **Maine Center for Disease Control and Prevention:** Best Practice Recommendations for Handoff Communication During Transport from a Home or Freestanding Birth Center To a Hospital Setting
  - Professional Competence Review Process (see p. 20)

Examples for Evaluation and Systems Improvements Tools

- **Oregon Community Birth Transfer Partnership**
  - **Community Birth Transfer Partnership Annual Audit Form (p. 37, Transfer Improvement Toolkit)**
  - **Community Birth Transfer Focus Group Guide (p. 72, Transfer Improvement Toolkit)**
  - **Patient and provider surveys, including detailed patient survey (pg. 43, Transfer Improvement Toolkit)**
- **Foundation for Health Care Quality:** Smooth Transitions Surveys for patients, nurses, doulas, EMS personnel, and transferring and receiving providers to provide qualitative data from the perspective of all parties involved in transfers:
  - Smooth Transitions Survey Card (with all the QR codes)
    - Smooth Transitions Surveys
  - Smooth Transitions Participating Facilities Annual Audit
  - Smooth Transitions Community Midwife Annual Audit
- **Utah Women and Newborns Quality Collaborative:** Out-of-Hospital Births Committee
  - Three Question Debriefing Form
  - Transfer Feedback Survey
  - Transfer Feedback Poster: **How to Share Your Birth Transfer Story**
  - Transfer Feedback Postcard

Examples for Evaluation and Systems Improvements Tools (Con't)

- **Maine Center for Disease Control and Prevention:** Best Practice Recommendations for Handoff Communication During Transport from a Home or Freestanding Birth Center To a Hospital Setting
  - Evaluation and Feedback about Transport Process (p. 23)
- **Baby+Co.**
  - Transfer surveys results (surveys administered after all intrapartum or postpartum/newborn transfers and reviewed quarterly between hospital and birth center)

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Provide Education and Training to Health Care Professionals on Health Equity and Respectful Care

Care providers, regardless of setting, should be trained in antiracist principles and recognition of implicit bias to optimize approaches to clinical care. Such education may increase awareness of patient groups who are vulnerable to discrimination and disparities in care based on race, ethnicity, education level, insurance coverage, English language proficiency, or other identities and factors that may lead to marginalization. In addition to training, professionals should also have ongoing opportunity to operationalize skills learned.

Examples of Free Educational Resources on Health Equity and Respectful Care

Resources	Brief Description
March of Dimes: Beyond Labels	This webpage provides interactive educational materials on how stigma can impact health care, as well as practical tools and resources to reduce stigma in health care settings. Includes links to additional websites, tools and toolkits, and evidence.
Association of Women's Health, Obstetric, and Neonatal Nurses: Insights	This podcast series, which targets obstetric care professionals, has several episodes focused on respectful care and health equity in obstetrics and gynecology. Episodes of note include Perinatal Bereavement, Native American and Alaska Native Heritage Month, Respectful Maternity Care, The Impact of Implicit Bias in Healthcare, and Shared Decision Making.
University at Albany School of Public Health: Bridging Gaps: The Vital Role of Cultural Competence in Healthcare	This recorded webinar and accompanying activity materials present fundamental concepts on cultural and linguistic competence for medical and public health professionals.
Department of Health and Human Services, Office of Minority Health: Fundamentals of the National Standards for Culturally and Linguistically Appropriate Services in Maternal Healthcare	This recorded webinar explores culturally and linguistically appropriate services (CLAS), why they matter, and how the National CLAS Standards can be implemented by healthcare organizations.

Examples of Free Educational Resources on Health Equity and Respectful Care (Con't)

Resources	Brief Description
Department of Health and Human Services, Office of Minority Health: Culturally and Linguistically Appropriate Services in Maternal Health Care	This 2-hour e-learning program is designed for providers seeking knowledge and skills related to cultural competency, cultural humility, person-centered care, and combating implicit bias across the continuum of maternal health care.
American College of Obstetricians and Gynecologists: Respectful Care eModules	These courses provide a breadth of knowledge that will help clinicians more effectively offer respectful care in obstetrics, gynecology, and overall patient health.
Institute for Perinatal Quality Improvement: SPEAK UP Training Modules	This e-learning program is designed for healthcare professionals who care for Black, Indigenous, and people of color who are or may become pregnant and focuses on implicit and explicit biases that contribute to inequities in care.
Michigan Department of Health & Human Services: Health Equity, Implicit Bias, Stigma and Antiracism	This compilation of resources provides several educational opportunities for health care providers to incorporate into their ongoing professional development and work.
Maryland Maternal Health Innovation Program: MDMOM Hospital Equity Initiative	The hospital equity initiative supports interventions to improve systems of care and eliminate maternal health inequities. It includes online trainings, skills building, and a toolkit.

Creating systems of care built on the concept of respectful care is essential to supporting health equity and ensuring risk-appropriate care. It is imperative to create a culture within systems that supports trust and respect between the community and health care systems. Interprofessional education and collaborative practices can serve as a catalyst for improving team-based patient care and enhancing population health outcomes.[1] The interprofessional QI team should work to create sustainable implementation plans that weave health equity into system practices via the workplan.

Included in this process is a shift from the goal of cultural competence to cultural humility. A long-held concept in health care, cultural competence promotes the idea that, by gaining knowledge, an individual might master understanding of a culture. While initially conceived to decrease bias and optimize care, is should be noted that there is potential in this reductive approach to create biases based on perceived "mastery".

Cultural humility, however, describes a "dynamic and lifelong process focusing on self-reflection and personal critique, acknowledging one's own biases."[2] Cultural humility involves understanding the complexity of identities—that even in sameness there is difference.[2] Understanding the cultural

complexities that exist within a risk-appropriate system of care may contribute to care that seeks to reduce mortality and morbidity. Providing education on traditional birthing practices and concepts by regions can aid in providing equitable and respectful care.

Resource

- **PsychHub:** What is Cultural Humility? This brief video describes the difference between cultural competence and cultural humility.

Apply Trauma-Informed Care Concepts for Patients, Their Identified Support Network, and Staff

Trauma-informed care is a framework that "recognizes the breadth of trauma experiences by patients outside of, and within, health care experiences."[3, 4, 5] This type of care recognizes and acknowledges the role trauma may play in an individual's life, including their interactions with medical and healthcare institutions.[4] Higher rates of trauma exposure have been reported among BIPOC and queer individuals.[6] For people who have intersectional identities, or more than one historically marginalized identity, this marginalization and trauma exposure may be compounded.

The goal of trauma-informed care is to deliver respectful care to all persons, integrating autonomy and trust into care, preventing retraumatization, and facilitating resilience and recovery among trauma survivors.[7] This approach should be provided to all seeking care, regardless of whether an individual chooses to disclose an exposure to trauma.

Because the way in which survivors approach health and health care can be influenced by their trauma, it is possible that some people who choose community birth settings do so because of traumatic experiences, whether outside of health care settings or as previous birth trauma.[6] This adds further complexity to the need for transfer to a hospital for care.

The Substance Abuse and Mental Health Services Administration states, "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being"; understanding this concept is critical for all members of a team supporting birth, regardless of setting of care.[7] Whether a patient has disclosed a history of trauma explicitly or is simply at risk for trauma during a community birth transfer or complex birth process, concepts of trauma-informed care should be integrated into all aspects of the QI team workplan and the care provided.

Resource

- ***British Journal of Anesthesia Education:*** Antepartum and intrapartum risk factors and the impact of PTSD on mother and child
  - A review of literature on peripartum posttraumatic stress disorder, including risk factors and management strategies.

Example Strategies for Trauma-Informed Clinical Care for All Birth Settings*

Trauma-Informed Care Phrasing for Examinations:

Phrasing to Use	Phrasing to Avoid
"You are in control the entire time."	"Open your legs wide."
"You tell me when to start or stop."	"Just relax."
"You tell me when you are ready."	"This won't feel like much."
"Your exam is normal and healthy."	"Everything looks or feels good."

Trauma-Informed Communication:

- Sit at or below eye level during conversations about consent and boundaries.
- Complete intake with patient while they are fully dressed.
- Use open body language.
- Use open and continued dialogue before, during, and after an examination to determine a person's preferences and needs for comfort and safety.

Actionable Best-Practices in Pelvic and Intimate Examination-Specific Trauma-Informed Care:

- Obtain explicit and ongoing consent for all examinations, especially those that involve breast or chest area or pelvic care.
- Offer flexible, progressive office visits to provide care at a person's own pace.
- Support of self-swabbing or self-speculum insertion.
- Allow choices regarding who is present for examinations.
- Get patient input on order of parts of an examination.
- Consider nontraditional positions for examinations or avoidance of lithotomy in stirrups if this is triggering for a person.

*Adapted from LoGiudice JA, Tillman S, Sarguru SS. A Midwifery Perspective on Trauma-Informed Care Clinical Recommendations. J Midwifery Womens Health. 2023 Mar;68(2):165-169. doi: 10.1111/jmwh.13462. Epub 2023 Jan 19. PMID: 36658770.

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