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.

References

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[2] Stapleton SR, Osborne C, Illuzzi J. Outcomes of care in birth centers: demonstration of a durable model. J Midwifery Womens Health. 2013;58(1):3-14. doi: 10.1111/jmwh.12003

[3] Nethery E, Schummers L, Levine A, Caughery AB, Souter V, Gordon W. Birth Outcomes for Planned Home and Licensed Freestanding Birth Center Births in Washington State. Obstet Gynecol. 2021;38(5):693-702. doi: 10.1097/AOG.0000000000004578

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