

# Implementing shared decision making in labor and delivery: TeamBirth is a model for person-centered birthing care

The TeamBirth practice model infuses shared decision making into labor and delivery culture and workflow, vesting patients as partners in their care

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### CASE The TeamBirth experience: Making a difference

“At a community hospital in Washington where we had implemented TeamBirth (a labor and delivery shared decision making model), a patient, her partner, a labor and delivery nurse, and myself (an ObGyn) were making a plan for the patient’s induction of labor admission. I asked the patient, a 29-year-old (G2P1001), how we could improve her care in relation to her first birth. Her answer was simple: I want to be treated with respect. Her partner went on to describe their past experience in which the provider was inappropriately texting while in between the patient’s knees during delivery. Our team had the opportunity to undo some

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of the trauma from her first birth. That’s what I like about TeamBirth. It gives every patient the opportunity, regardless of their background, to define safety and participate in their care experience.”

—Angela Chien, MD, Obstetrician and Quality Improvement leader, Washington

Unfortunately, disrespect and mistreatment are far from an anomaly in the obstetrics setting. In a systematic review of respectful maternity care, the World Health Organization delineated 7 dimensions of maternal mistreatment: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and poor conditions and constraints presented by the health system.<sup>1</sup> In 2019, the Giving Voice to Mothers study showed that 17% of birthing people in the United States reported experiencing 1 or more types of maternal mistreatment.<sup>2</sup> Rates of mistreatment were disproportionately greater in populations of color, hospital-based births, and among those with social, economic, or health challenges.<sup>2</sup> It is well known that Black and African American and American Indian and Alaska Native populations experience the rare events of severe maternal morbidity and mortality more

**FIGURE 1** Shared planning board use



TeamBirth utilizes a shared planning board to facilitate patient-centered decision making. This template planning board is customized by hospitals and birth centers to suit their language preferences and individual needs.

<b>Labor and Birth Planning Board</b>		DATE: ROOM:
TEAM	PREFERENCES	PLAN FOR Mother: Baby: Labor Progress:
		NEXT HUDDLE
		PRE-LABOR   EARLY LABOR   ACTIVE LABOR   PUSHING

frequently than their White counterparts; the disproportionate burden of mistreatment is lesser known and far more common.

Overlooking the longitudinal harm of a negative birth experience has cascading impact. While an empowering perinatal experience can foster preventive screening and management of chronic disease, a poor experience conversely can seed mistrust at an individual, generational, and community level.

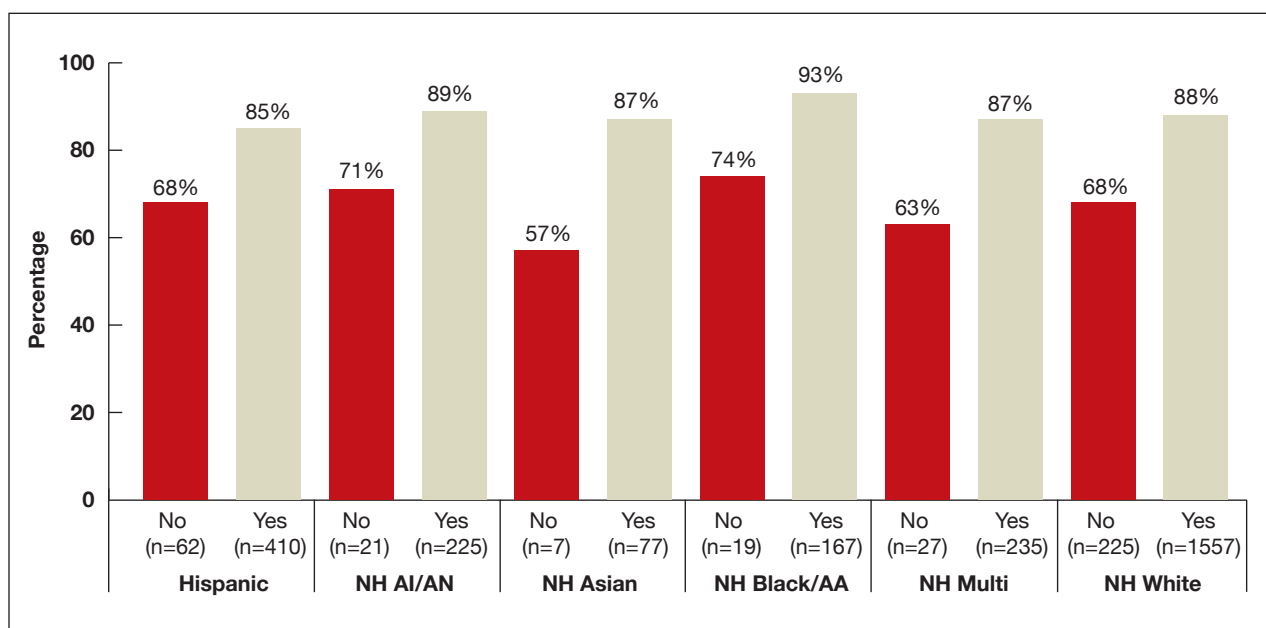
The patient quality enterprise is beginning to shift attention toward maternal experience with the development of PREMs (patient-reported experience measures), PROMs (patient-reported outcome measures), and novel validated scales that assess autonomy and trust.<sup>3</sup> Development of a maternal Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on childbirth is forthcoming.<sup>4</sup> Of course, con-

tinuing to prioritize physical safety through initiatives on blood pressure monitoring and severe maternal morbidity and mortality remains paramount. Yet emotional and psychological safety also must be recognized as essential pillars of patient safety. Transgressions related to autonomy and dignity, as well as racism, sexism, classicism, and ableism, should be treated as “adverse and never events.”<sup>5</sup>

### How the TeamBirth model works

Shared decision making (SDM) is cited in medical pedagogy as the solution to respectfully

**FIGURE 2 Patient autonomy scores were higher in huddle participants**



In a cohort of hospitals in Oklahoma, patients completed the Mothers Autonomy in Decision Making (MADM) validated survey. High autonomy scores reflecting the top quartile of responses are shown, differentiated by patient-reported race/ethnicity. The red bar represents patients who did *not* report participating in a TeamBirth huddle while the tan bar represents patients who did report participating in a TeamBirth huddle. Across racial and ethnic identities, the percentage of patients scoring in the highest MADM quartile was 31.3% higher for patients who reported participating in a huddle during labor compared with those who did not participate in a huddle.

Abbreviations: AA, African American, AI/AN, American Indian/Alaska Native, NH, non-Hispanic.

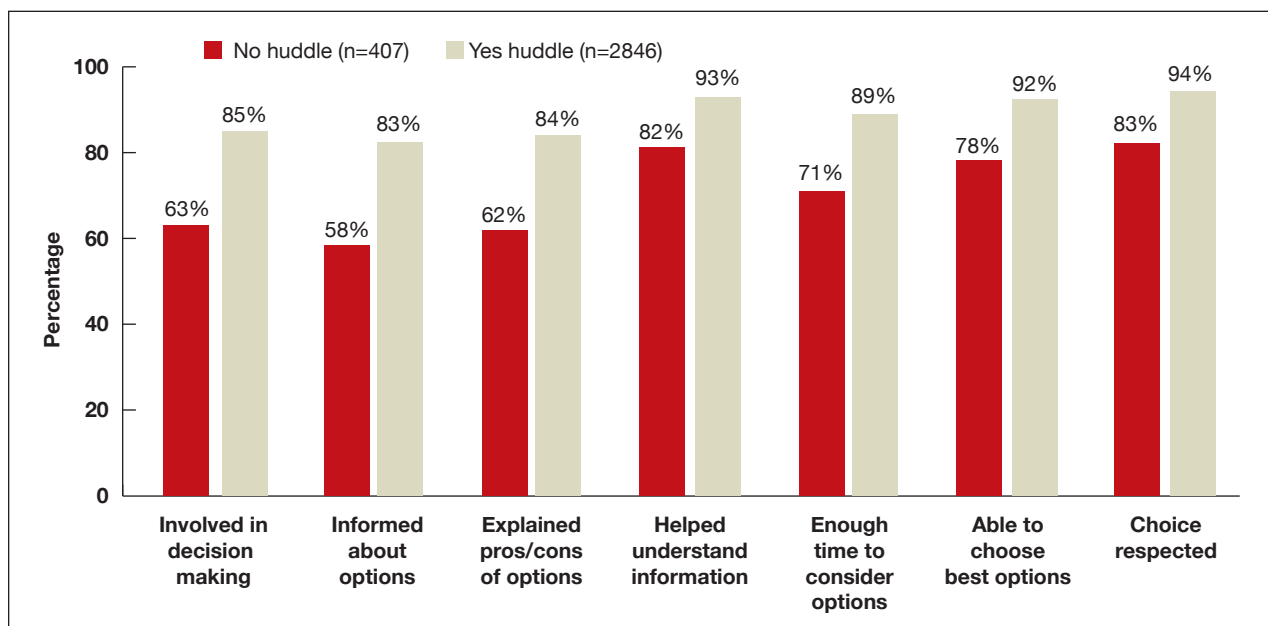
recognizing social context, integrating subjective experience, and honoring patient autonomy.<sup>6</sup> The onus has always been on individual clinicians to exercise SDM. A new practice model, TeamBirth, embeds SDM into the culture and workflow. It offers a behavioral framework to mitigate implicit bias and operationalizes SDM tools, such that every patient is an empowered participant in their care.

TeamBirth was created through Ariadne Labs' Delivery Decisions Initiative, a research and social impact program that designs, tests, and scales transformative, systems-level solutions that promote quality, equity, and dignity in childbirth. By the end of 2023, TeamBirth will be implemented in more than 100 hospitals across the United States, cumulatively touching over 200,000 lives. (For more information on the TeamBirth model, view the "Why TeamBirth" video at: <https://www.youtube.com/watch?v=EoVrSaGk7gc>.)

The tenets of TeamBirth are enacted through a patient-facing, shared whiteboard or dry-erase planning board in the labor room (FIGURE 1, page 33). Research has demonstrated how dry-erase boards in clinical settings can support safety and dignity in care, especially to improve patient-provider communication, teamwork, and patient satisfaction.<sup>7,8</sup> The planning board is initially filled out by a clinical team member and is updated during team "huddles" throughout labor.

Huddles are care plan discussions with the full care team (the patient, nurse, doula and/or other support person(s), delivering provider, and interpreter or social worker as needed). At a minimum, huddles occur on admission, with changes to the clinical course and care plan, and at the request of any team member. Huddles can transpire through in-person, virtual, or phone communication.<sup>9</sup> The concept builds on

**FIGURE 3 Patient agreement with MADM items was higher in huddle participants**



Shown are the 7 items included in the Mothers Autonomy in Decision Making (MADM) scale. In a cohort of Oklahoma hospitals, patients who indicated participation in a TeamBirth huddle, represented by the tan bar, reported a higher percentage of strong and complete agreement for every MADM item when compared with patients who did not indicate participation in a huddle, as represented by the red bar. On average, across items, MADM scores increased by 18%.

interdisciplinary and patient-centered rounding and establishes a communication system that is suited to the dynamic environment and amplified patient autonomy unique to labor and delivery. Dr. Bob Barbieri, a steadfast leader and champion of TeamBirth implementation at Brigham and Women’s Hospital in Boston (and the Editor in Chief of OBG MANAGEMENT), recognized the importance of the dry-erase board in “memorializing the decisions made.”

### Patient response to TeamBirth is positive

Patients and providers alike have endorsed TeamBirth. In initial pilot testing across 4 sites, 99% of all patients surveyed “definitely” or “somewhat” had the role they wanted in making decisions about their labor.<sup>9</sup>

In partnership with the Oklahoma Perinatal Quality Improvement Collaborative (OPQIC), the impact of TeamBirth was assessed in a statewide patient cohort

(n = 3,121) using the validated Mothers Autonomy in Decision Making (MADM) scale created by the Birth Place Lab at the University of British Columbia. The percentage of patients who scored in the highest MADM quartile was 31.3% higher for patients who indicated participation in a huddle during labor compared with those who did not participate in a huddle. This trend held across all racial and ethnic groups: For example, 93% of non-Hispanic Black/African American patients who had a TeamBirth huddle reported high autonomy, a nearly 20 percentage point increase from those without a huddle (FIGURE 2). Similarly, a higher percentage of agreement was observed across all 7 items in the MADM scale for patients who reported a TeamBirth huddle (FIGURE 3). TeamBirth’s effect has been observed across surveys and multiple validated metrics.

Data collection related to TeamBirth continues to be ongoing, with reported values retrieved on July 14, 2023. Rigorous review of patient-reported outcomes is forthcoming,

and assessing impact on clinical outcomes, such as NTSV (nulliparous, term, singleton vertex) cesarean delivery rates and severe maternal morbidity, is on the horizon.

Qualitative survey responses reinforce how patients value TeamBirth and appreciate huddles and whiteboards.

### Patient testimonials

The following testimonials were obtained from a TeamBirth survey that patients in participating Massachusetts hospitals completed in the postpartum unit prior to discharge.

According to one patient, “TeamBirth is great, feels like all obstacles are covered by multiple people with many talents, expertise. Feels like mom is part of the process, much different than my delivery 2 years ago when I felt like things were decided for me/I was ‘told’ what we were doing and questioned if I felt uneasy about it.... We felt safe and like all things were covered no matter what may happen.”

Another patient, also at a Massachusetts hospital, offered these comments about TeamBirth: “The entire staff was very genuine and my experience the best it could be. They deserve updated whiteboards in every room. I found them to be very useful.”

### The clinician perspective

To be certain, clinician workflow must be a consideration for any practice change. The feasibility, acceptability, and safety of the TeamBirth model to clinicians was validated through a study at 4 community hospitals across the United States in which TeamBirth had been implemented in the 8 months prior.<sup>9</sup>

The clinician response rate was an impressive 78%. Ninety percent of clinicians, including physicians, midwives, and nurses, indicated that they would “definitely” (68%) or “probably” (22%) recommend TeamBirth for use in other labor and delivery units. None of the clinicians surveyed (n = 375) reported that TeamBirth negatively impacted care delivery.<sup>9</sup>

Obstetricians also provided qualitative

commentary, noting that, while at times huddling infringed on efficiency, it also enhanced staff fulfillment. An obstetrician at a Massachusetts hospital observed, “Overall I think [TeamBirth is] helpful in slowing us down a little bit to really make sure that we’re providing the human part of the care, like the communication, and not just the medical care. And I think most providers value the human part and the communication. You know, we all think most providers value good communication with the patients, but when you’re in the middle of running around doing a bunch of stuff, you don’t always remember to prioritize it. And I think that at the end of the day...when you know you’ve communicated well with your patients, you end up feeling better about what you’re doing.”

As with most cross-sectional survey studies, selection bias remains an important caveat; patients and providers may decide to complete or not complete voluntary surveys based on particularly positive or negative experiences.

Metrics aside, obstetricians have an ethical duty to provide dignified and safe care, both physically and psychologically. Collectively, as a specialty, we share the responsibility to mitigate maternal mistreatment. As individuals, we can prevent perpetuation of birth trauma and foster healing and empowerment, one patient at a time, by employing tenets of TeamBirth.

### Steps for implementing the TeamBirth model

To incorporate TeamBirth into your practice:

- Make patients the “team captain” and center them as the primary decision maker.
- Elicit patient preferences and subjective

### For more information

To connect with Delivery Decisions Initiative, visit our website: <https://www.ariadnelabs.org/delivery-decisions-initiative/> or contact: [deliverydecisions@ariadnelabs.org](mailto:deliverydecisions@ariadnelabs.org)

### FAST TRACK

*The feasibility, acceptability, and safety of the TeamBirth model to clinicians was validated through a study at 4 community hospitals across the US in which TeamBirth had been implemented in the 8 months prior*

- experiences to develop a collaborative plan on admission and when changes occur in clinical status.
- Round with and utilize the expertise of the full care team—nurse and midwife or obstetrician, as well as support person(s) and/or doula, learners, interpreter, and social worker as applicable.
  - Ensure that the patient knows the names and roles of the care team members and provide updates at shift change.
  - If your birthing rooms have a whiteboard, use it to keep the patient and team informed of the plan.
  - Delineate status updates by maternal condition, fetal condition, and labor progress.
  - Provide explicit permission for patients to call for a team huddle at any time and encourage support from their support people and/or doula. ●

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