Oregon Perinatal Collaborative

Community Birth Transfer Partnership Focus Group Report

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In February, 2021 the Oregon Community Birth Transfer Partnership (CBTP), a joint program of the Oregon Perinatal Collaborative and the Oregon Midwifery Council, conducted focus groups to collect information from birthing parents who experienced a transfer from a planned home birth or birth center birth in Oregon. Participants were asked about their transfer experiences and their feedback for quality improvement of community birth transfers. 14 birthing parents participated in 4 focus groups: one for birthing parents who are Black, Indigenous, and People of Color, one for maternal transfers in the Portland Metro area, one for maternal transfers in other parts of the state, and one for parents whose babies had been in the neonatal intensive care unit. This report is a summary of their responses for use in the program development phase of the CBTP.

It was important to us to hear from birthing parents who are Black, Indigenous, and People of Color (BIPOC) about their experiences and recommendations for improving community birth transfers. BIPOC birthing parents have expert advice to offer us on how to respond to the crisis in maternal and infant health caused by racism. The input of BIPOC birthing parents can help us reduce harm and improve outcomes and the experience of care for birthing families. We have highlighted the input of BIPOC participants throughout this report and have included a section on their specific recommendations to improve care for BIPOC families.

Birthing Parent Experiences and Feedback

Birthing parents shared illuminating information about their birth experiences and the ways that community birth to hospital transfers could be improved. The following are the core themes that emerged from all four focus groups.

Respect

Respect was a key theme in the focus groups. Since respect had been such a consistent value for survey respondents, we asked focus group participants to describe what respect meant to them and how they would know they were being respected during birth and postpartum. Participants wanted providers to ask them about their preferences and plans, provide complete informed choice, and respect their decisions without attempts at coercion. They wanted providers to remember that they work for birthing people, who are in charge of making decisions about their bodies and their babies. They wanted providers and nurses to listen to them, welcome questions and welcome it when they advocated for themselves. The wanted to be included as full partners in their care. They also wanted verbal consent for all procedures including routine things like taking a blood pressure. To the focus group participants, respect means:

“Giving me the information and then trusting me enough to know that I can make a decision for myself based on that information without fear mongering… All of us want to be safe ourselves, and we want our babies to be safe, and if you lay out the information and present all the information to us, I think you should respect us enough to know that we will make the right choice based on that information.”

“Not only just listen to what I value but also work to implement those things for me… Look at it as a partnership.”

“Being truly listened to… my preferences and values being taken into account… my voice being the authority, the ultimate authority in the birth situation.”

“Treat someone else how you want to be treated… like I am a human being, you are a human being, I am capable of making decisions, you are capable of making decisions…. We might have completely different beliefs and we might have completely different value systems and like that's fine and that's something that… Yes, I may believe something different, but that doesn't mean that my belief is wrong and that doesn't mean that I am any less than anybody else.”

“I want looped in the conversation when it comes to my own care and the care of my child.”

Reasons for Choosing Community Birth

Focus group participants often described their reasons for choosing a home birth and expressed their desire for hospital providers and nurses to understand these motivations. This was especially important to participants in the BIPOC focus group who wanted hospital providers and nurses to understand that avoiding institutional racism and a desire to observe cultural traditions were part of their decision-making. One Black participant expressed that she was afraid to give birth in the hospital because of the experiences of Black moms who have not been listened to or believed about their concerns in hospital care. Another participant in the BIPOC focus group shared what she wanted hospitals to understand about these choices,

"I think that the medical community, hospitals and clinics specifically need to have an awareness that some people's preference for more like natural or low-intervention birth is cultural and not just like some hippie new age movement. That it's actually a return to roots and actually very important on like a spiritual level for people."

Several focus group participants shared that they chose home birth specifically because of safety so it was jarring to feel judged by the hospital as though they had made a choice that was unsafe or endangering. Participants shared that they researched their options and made educated choices to have a community birth. They were frustrated to find that some hospital staff perceived community birth as an uneducated choice. Participants also talked about choosing community birth as a way to have autonomy and control during birth.

"I chose a home birth because I've seen what happens in the hospital and I wanted the autonomy to say what was happening in my birth and to know that no means no and that every procedure, everything would be ran through me first."

"Home birth is a way for women to take back a strength that they have"

Contrasting Experiences of Care in Home and Hospital

Focus group participants frequently contrasted their experiences of community midwifery care and hospital care in ways that may be illuminating for providers and nurses seeking to understand the differences in these models of care. They described feeling like active and central participants in their care with community midwives but being pushed to a secondary or lesser position when they transferred to the hospital. One participant articulated that she felt like she had to be accommodating to the staff, rules, policies, once she entered the hospital.

"At home, I was very much a part of every decision that we made. I am capable of being a member of a decision-making team like it's my life, it's my child's life. And, it felt like at the hospital, instead of being treated like the mother of my child, I was also being treated like a child."

"I feel like I'm a chart and not a person and so they're looking at the numbers first and not me as an individual versus, be like, I see you're a person, also these numbers are here. Like numbers don't tell a whole story and never will and so like why aren't you asking questions about like my experience and what I'm looking for?"

Participants also described feeling celebrated and surrounded by encouragement while they labored at home and lamented the loss of a sense of celebration and magic in the hospital setting.

"It was so exciting, it was like I'm bringing life into the world, and then I get to the hospital and it's just like let's hook her up to the two machines and let's watch these numbers and everything just felt like it was taking away the magic."

Good Care

Focus group participants had clear ideas of what constitutes good care. Much of their conception of good care centered around slowing down, listening, and offering kindness. They emphasized that birth and hospital transfer experiences affected them for months and years and providers need to understand how large their impact can be. They liked it when

providers took the time to listen, provide explanation, and give space and time to process major decisions. BIPOC participants emphasized that each birthing person is unique and birth is not a production line. The following are elements of good care that focus group participants described:

- Slow down and listen
- Recognize us as whole people
- Talk us through what is about to happen
- Offer kindness and gentleness
    - Small kindnesses like a NICU nurse supporting skin-to-skin after initial mother-baby separation and a CNM bringing a picture of a baby to a mom recovering from a cesarean before she could see him made a big difference
- Don't share information or talk about decisions during contractions
- Partner with the birthing person as an active member of the care team
- Offer empathy about wanting a home birth and about the challenges of a hospital transfer
- Check in and answer questions after and emergency or surgery

Participants appreciated seeing the hospital staff and community midwife work collaboratively together. Those who had midwife-to-midwife transfer were pleased with the option.

"I literally wouldn't have changed anything about how my midwife handled it before, during or after I think it was fantastic, and I think the relationship they had with the hospital is amazing."

When participants did not feel that they had received good care, it was often related to not being listened to and not having their questions answered.

"During the C section I was shaking and scared and I don't feel like anyone really addressed like my questions asking of like, is this normal that I'm shaking? when will it stop?"

There was a fairly stark difference between participants perception of intrapartum and postpartum care. Many focus group participants said that they had good labor and birth experiences but bad postpartum experiences due to interruptions, judgement, and lack of support.

Community Midwife as Support, Comfort, and Advocate

Continuity of care with their community midwife was important to all the focus group participants but especially the BIPOC participants. Participants described a trust relationship with their midwives that they relied on in an unfamiliar or distressing situation. They described their midwife as a translator, explaining things in language they understood. When their community midwife had relationships with the hospital, they felt like it eased the experience of transfer. Participants were upset when the community midwife was treated poorly or seen as a "visitor" rather than a member of the care team. Several participants experienced the community midwife as a buffer or protector when a hospital provider was being aggressive or threatening.

"It was really nice have my midwife there because it was somebody I trusted and had seen throughout the duration of my care. When they were asking… can we put you know, like a heart rate, monitor and baby's head… I didn't look at them to ask the questions, I looked at my midwives like, Is this something that's okay? …. So, it was really nice to know like, somebody that I trusted and felt was very competent was there, and you could just see the relationship between my midwives and their midwives was very strong."

Participants appreciated it when their midwife could be with them throughout each step of the transfer process including being with them in the ambulance and in the operating room. A number of participants described how useful it

was for them that their community midwife walked them through what would happen during the transfer, or what was happening during a procedure, step-by-step.

“My midwife got to stay with me through the entire delivery…She was reassuring me, letting me know what was going on…She talked me through everything that was happening.”

Informed Choice

Focus group participants wanted to see the model of informed choice that they experienced in midwifery care adopted in the hospital. They wanted clear informed choice with full information on risks, benefits, and alternatives. They wanted time to consider their options and respect for their decisions without continued attempts to persuade them if they chose something other than what was recommended. They described the need for informed choice even in emergency situations. Participants wanted to remind providers that birthing people are focused on the safety of their babies and should be trusted to make decisions. They wanted providers to know that lack of consent causes trauma. They recognized that something can be painful or hard but not traumatizing when the birthing person is a consenting and active partner.

“What I loved about my midwives, is that they said, you know here are the options, these are the pros, these are the cons… you make the decision.”

“With my midwives, they were also, like the best example of consent I've ever had where they're like about to do something they're like Okay, let me tell you what's going to happen, you can stop at any point. I don't know that anything happened that was terrible in that sense in the hospital, but I felt the absence of the conversation. Of like, let me explain what's going to happen. When that's missing… you're just left to fill in the blanks.”

“I have the choice, and I have the ability to decide what's best for my body, and for my baby.”

Preparation for Transfer

Most of the participants felt mentally prepared for transfer but not emotionally prepared. Many reported that, though their midwife described transfer, they did not think it would happen to them. Some described themselves as being in denial about the possibility of transfer. Participants in the Portland metro area reported more midwife preparation for hospital transfer than those in other parts of the state. Those participants who did feel prepared for hospital transfer described more detailed planning conversations with their community midwife.

[Transfer]was definitely talked about as… a very real possibility. I'm a first-time mom too so it's definitely something my midwives went over like at our first visit and we had… our hospital bag all packed. Everything was prepared for that possibility. But I think in my head, I still kind of felt like it wouldn't happen.”

“My midwives prepared me that it was a possibility and also gave some pretty clear guidelines of when… we had reached the safety level for their practice and their care, but I personally was in denial that it would ever happen to me. And so, I mentally was not prepared for that move. I did not have a hospital bag packed. I'm actually a CNM so I thought I knew it all and that I knew what to expect, and I was wrong.”

“*[The midwives] talked about common reasons people are transferred… Yeah, I mean just in every appointment checking in like what might be indicators that we might need to transfer. They gave us a form that I think was more for us [with] what things are important in the birthing process, whether it's home birth or hospital birth that we really want as part of our experience. So I mean that was really helpful… especially since like once we got to the hospital… she was able to keep some of those things in mind.”*

Focus group participants offered advice for community midwives to improve transfer preparation. There was an emphasis on the importance of repeated conversations and offering information in multiple formats. Their specific recommendations for improving transfer preparation are included later in this report.

Bias and Mistreatment

Black, Indigenous and People of Color focus group participants reported more experiences of mistreatment or abuse within the hospital than white participants. An Indigenous participant described being threatened with a call to Child Protective Services if she did not comply with a treatment plan. She felt that she was viewed as difficult and combative when she tried to advocate for herself. When she reflected on the experience of other Indigenous mothers she knows or supported during birth, she said that they were treated well if they were compliant and passive and treated poorly if they advocated for themselves or expressed that they didn't like something. A Black participant described a provider stating that she was too high risk for VBAC because of being Black. BIPOC participants described these experiences as contributing to their perception that the hospital was not a welcoming place for people of their race/ethnicity.

The most frequent forms of mistreatment reported by focus group participants were threats and verbal abuse. Participants described feeling demeaned and angry when they were threatened by obstetricians or pediatricians when they did not consent to testing or treatment. Multiple participants reported threats that insurance would not cover their care if they did not consent to a recommended plan. They wanted providers and nurses to understand that many people already have had experiences of medical mistreatment before they give birth and these behaviors bring up those experiences and undermine the care relationship.

"The nurse in Labor and delivery kind of was not so nicely yelling at me to not push in the hallway when I couldn't particularly control it"

"The OB… gave me a veiled warning like, if you don't push him out this next time and, like left this big hanging thing. I really didn't appreciate that."

A number of participants reported that hospital providers or nurses were dismissive and made assumptions because they had planned a home birth. They wanted hospital staff to understand that they planned to give birth at home for a reason and that they were transferring for a reason and needed understanding not judgement. Participants also described bias from providers during when they accessed screening or additional care prenatally. These experiences exacerbated distrust of the hospital.

"I had my 20 week ultrasound [and] the ultrasound tech and the doctor were like, you should transfer your care to [hospital]. It's just this type of thing, like well why are you trying to pressure me into doing that?"

Separation of Mother and Baby

Participants reported that any separation from their baby was extremely painful. Participants used strong language in describing these separations with one person saying that she felt "crazy with the need" see her baby. They expressed heartbreak and grief at the loss of the golden hour and did not accept that the separation was necessary. They wanted hospitals to understand that practices and facilities should be structured around keeping mothers and babies together. One participant wanted providers to know that even a few minutes with her baby before he was taken to the NICU would have made a big difference. One person said that the presence of her community midwife in the recovery room before she could see her baby was helpful. Another expressed that she wanted to see more understanding in the hospital of the mental health impacts of mother-baby separation.

"After I had my C section, when I wanted to see my son, yes I'm super grateful that he's healthy and he's breathing. But I also can do nothing to fight this absolutely intensive biological urge to hop out of this bed while my body is still numb and run and find wherever the NICU is and get to him."

Neonatal Intensive Care Unit

Concerns about respect, autonomy, and informed choice were accentuated for those participants who had babies in the Neonatal Intensive Care Unit (NICU). They reported that it was challenging to impossible to have their plans and preferences for newborn care honored by hospital staff. They wanted recognition from providers and nurses about the trauma of having a baby in the NICU. Participants wanted NICU providers and nurses to collaborate with them as members of the baby's care team. The NICU experience was especially challenging for those participants whose babies were in NICUs that did not have rooming in. Some participants described feeling like they had to fight to be discharged because the providers viewed them as unsafe because they planned a home birth.

"The majority of the time I'd get there and they'd already be feeding her formula… but I had already pumped stuff to give to her, and I was there to breastfeed her and it just didn't matter."

"We weren't allowed to fall asleep in the chair sitting in the NICU so I mean it was after 48 hours of labor and no sleep, I then had to, if I wanted to see my daughter and be near her, I had to stay awake in the NICU."

Postpartum Care

Many focus group participants reported that they had good experiences during labor and birth but not during postpartum care. There was agreement among participants that hospitals need to improve their postpartum care, both in the hospital and following discharge. They especially thought that follow-up care after cesarean section and hospital communication with the community midwife about follow up care should be improved.

"The transfer was amazing. The birth was amazing. It was afterwards, where it was just like we felt like we had to fight for everything."

"At one point my partner actually like stood outside the room and wouldn't let anybody come in, because it was just so disruptive and I couldn't sleep and if we had to do this again, I think he would do that more or we would have been more empowered to say like please, we don't want anyone for the next four hours or something because I really don't think coming in every two hours is necessary medically."

"The most shocking to me was how much attention I was getting up until like my baby left my body, and then there was, like the only follow care by my health care provider was a six-month video appointment and so that was it. Like I had a C section and there's like zero follow up and I had to like fight for pelvic floor therapy."

Recommendations for Community Birth Transfer Improvement

Focus group participants were asked for their recommendations on how community midwives and hospitals could improve the community birth transfer process. The following is a summary of their recommendations divided into specific areas for improvement.

Recommendations to improve experiences and outcomes for BIPOC families

- Listen to women. Listen to mothers
- Recognize that birth is physical, emotional, and spiritual
- Recognize that birthing people need their support people and accommodate them
- Provide care and support in the birthing person's primary language
- Work towards the goal of collaborative co-care between community midwives and hospital providers

- Provide public education about birth options, midwives, and community birth
    - Especially in BIPOC communities and rural areas
    - Include information on changing care providers if it is not a good fit
- Welcome the community midwife into the hospital.
    - The birthing person wants her there and may experience her as protective in a system that she wanted to avoid
- Provide training for hospital providers on cultural awareness and mortality/morbidity experienced by Black moms and babies
- Mandate universal insurance coverage of midwives and doulas
- Increase OHP payment for doulas

Recommendations for Community Midwives

- Community midwives should increase and improve preparation for hospital transfers
    - Encourage preregistration at the hospital
    - Encourage packing a hospital bag
    - Create an individual written transfer plan with documentation of preferences and choices for care (such as newborn procedures)
    - Provide education about what to expect in the hospital
    - Use handouts for hospital transfer education
- Ask for feedback from clients who transfer and adjust practices based on feedback

Recommendations for Hospital Staff

- Treat the birthing person like a partner in their care
- Welcome and include the community midwife
- Respect parent choices about newborn care
- Don't judge birth choices or parenting choices
- Acknowledge that the transfer is a major transition and this isn't where she wanted to be
- Validate the birthing person's experience
- Ask the birthing person why she wanted a home birth and how she is feeling about the transition to the hospital
- Don't talk down to birthing people verbally or physically (get down to their level)
- Take more time to explain procedures and why they need to do something
- Remove the stigma around planning a home birth
- Don't rush. Slow down.
- Give birthing person a chance to consider and consent before continuing talking or acting

Recommendations for Hospital Systems

- Provide education for hospital staff on midwives and community birth
- Provide education for pediatricians on midwife newborn scope of care
- Provide training for staff on informed choice, respectful care, and empathy
- Create clear communication protocols for incoming transfers
- Create protocols so that community birth transfers can go straight to L&D not the ED
- Improve inpatient postpartum with a focus on respect, informed choice, and minimizing disruptions during rest
- Increase postpartum care and support after discharge for all families
- Change hospital rooms to be more comfortable and feel less medical

- Create policies and physical areas for birthing people go outdoors during labor

Collaborative Recommendations

- Hospital providers and community meet regularly to build relationships
- Community midwives and hospital providers work on clear communication about level of urgency of care
- Community midwives and hospital work together on communication with EMS
- Provide continuing education for community midwives on cesarean recovery

System-Level Recommendations

- Mandate full insurance coverage for midwives, birth centers, and home birth
- Financially de-incentivize cesarean section

Report compiled by Silke Akerson.