CMQCC
California Maternal
Quality Care Collaborative

Partnering with Doulas to Improve Perinatal Outcomes and Promote Birth Equity

Facilitator:
Holly Smith, MPH, CNM, FACNM

Panelists:
Ann Fulcher, CLE, CD
Michelle Sanders, CD, CLEC

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Inclusive Language Notice

Currently recognized identifiers such as **“birthing people,” “mother**,” **“maternal,” “they,” “them,**” **“she,**” **“her.”** and **“pregnancy-capable person”** are used in reference to a person who is pregnant or has given birth.

We recognize not all people who become pregnant and give birth identify as mothers or women and will use the above-recognized terms interchangeably to represent all those present in this space receiving care for pregnancy services. All persons are equally deserving of respectful patient-centered care that helps them attain their full potential and live authentic, healthy lives. The healthcare team should respect individual patient preferences regarding gendered language throughout the course of their care.

The term **“family”** is used to refer to any persons the pregnant or postpartum patient designates as such (alternatives: partners, husbands, wives, support persons, loved ones).

The term **“clinician”** is used to denote nursing and medical staff, whereas the term **“provider”** refers to a clinician with diagnosing and prescribing authority.

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Today's Facilitator and Panelists

Holly Smith, CNM, MPH, FACNM
Project Lead, CMQCC Toolkit to Support Vaginal Birth

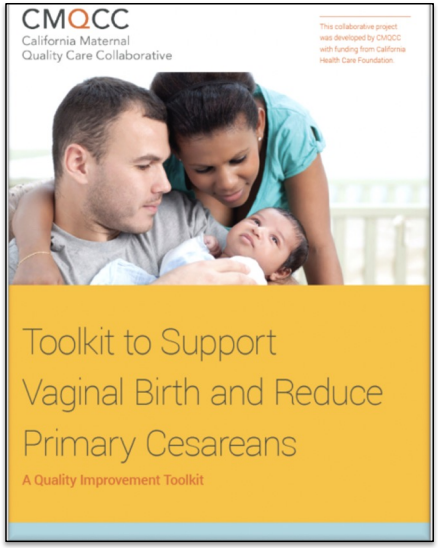
Michelle Sanders, CD, CLEC
Founder/Executive Director, Beauty for Ashes Maternal Wellness Inc.

Ann Fulcher CLE, CD
Manager, Volunteer Doula Program
UC San Diego Health

Objectives

- Understand the role of doulas in improving perinatal outcomes
- Demonstrate the concept of "doula as advocate" and why this role is critical in reducing racism-based disparities
- Understand the different types of doula programs that exist (e.g., volunteer hospital programs and community doula collectives)
- Summarize strategies for partnering with doulas to improve outcomes

This is Webinar **#4** in a Five-Part Series



1. The Next Step in California's Quality Improvement Journey: Integrating midwives, doulas, & community-based birth care (Nov 30, 2022)

2. Harnessing the Power of Team-Based Care to Improve Maternity Outcomes (Feb 3, 2023)

3. Tackling the Midwife Question: What is midwifery integration and why is it important for moms and birthing people in California? (May 9, 2023)

4. Partnering with Doulas (Aug 30, 2023)

5. Community Birth: Improving transfer of care (Oct 25, 2023)

Recordings at https://www.cmqcc.org/resources-tool-kits/webinars

The Elephant in the Zoom

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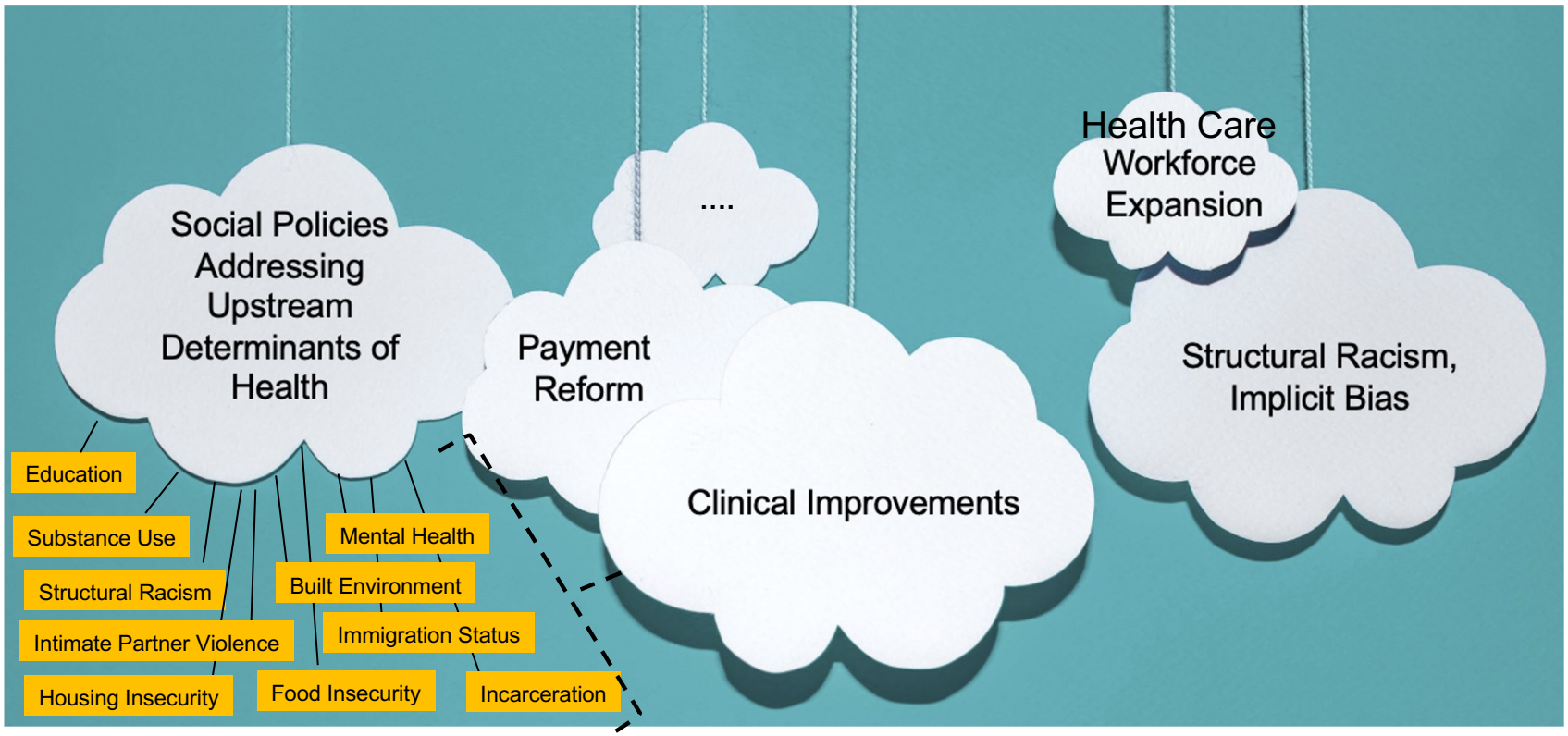
Maternity Care Improvement Ecosystem



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Partnering with Doulas (and midwives, and community birth…) to Improve Outcomes

Patient-Centered Care: *"Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring* ***that patient values guide all clinical decisions****."* – Institute of Medicine | Institute for Health Care Improvement

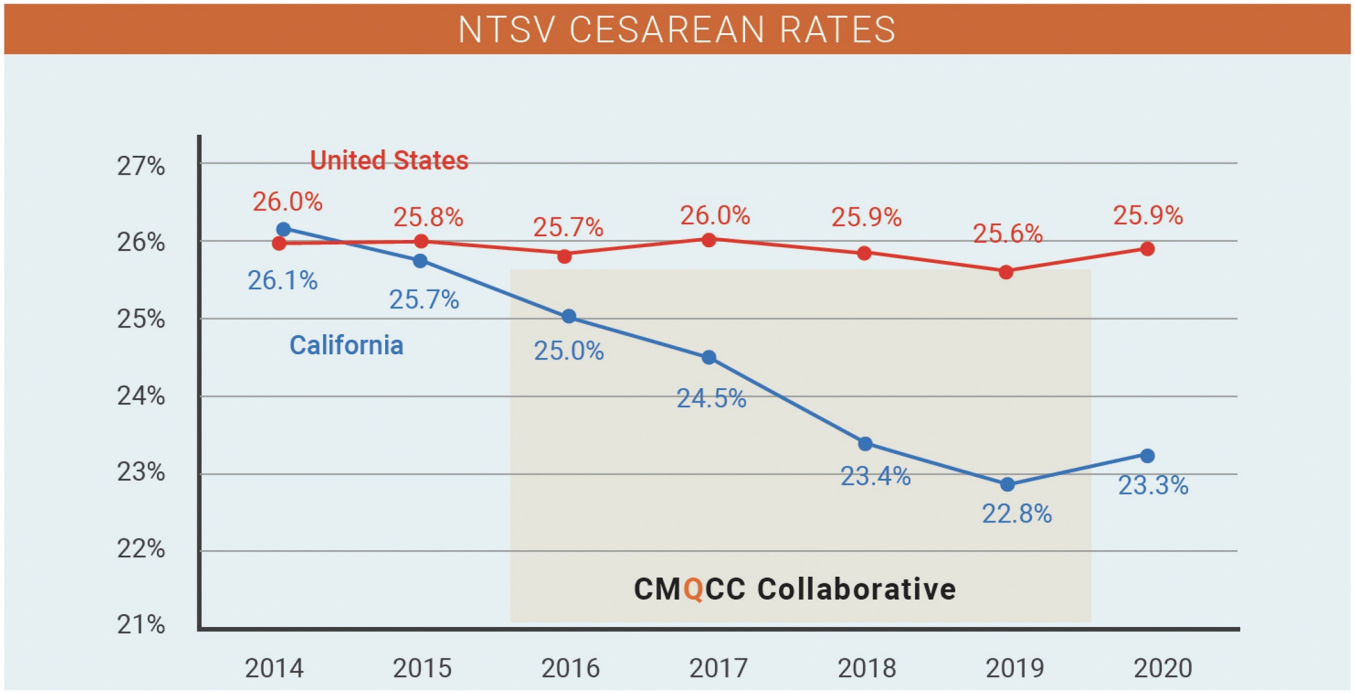
There is no singular intervention that is a silver bullet – time to use all the tools!

Doulas are critical patient advocates and connectors to services, just as much as they are there for labor support

Community birth is safe (home and birth center birth) when:

- trained, skilled providers (not just CNMs!)
- ongoing risk assessment;
- when medical consultation and higher levels of care are easily accessible

Landscape of Cesarean Birth in California
(compared to United States, pre- and post-collaborative)



Source of US Data: National Vital Statistics System – Natality (NVSS-N), CDC/NCHS
Source of CA Data: CMQCC Maternal Data Center based on linked patient discharge and birth certificate data

Image source: CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Most Frequently Utilized Interventions by Participating Hospitals

Specific Intervention	Percentage of Hospitals (n=91)
Staff Education on Normal Labor	98%
Sharing Unblinded Provider NTSV Rate	85%
Labor Dystocia Checklist	65%
Peanut Balls for Positional Support in Labor	53%
Active Phase Huddle	45%
Changes in Latent Labor Management	45%
Patient Education During Labor	45%
Induction Scheduling Form	34%
Doula Program	33%
Patient Support after Traumatic Birth Experience	26%
Electronic Medical Record Order Sets	24%
Induction of Labor Algorithm	22%
Cervical Ripening in Outpatient Setting	19%
Changes in 2nd Stage Management	18%
Coping with Labor Algorithm	10%
Introduction of Laborists	8%
Childbirth Education in Prenatal Period	8%
Introduction of Midwives	4%
Use of Nitrous Oxide	4%

Adapted from: Rosenstein MG, Chang SC, Sakowski C, et al. Hospital Quality Improvement Interventions, Statewide Policy Initiatives, and Rates of Cesarean Delivery for Nulliparous, Term, Singleton, Vertex Births in California. *JAMA*. Apr 27 2021;325(16):1631-1639. Image source: CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

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Cesarean Disparities by Race and Ethnicity

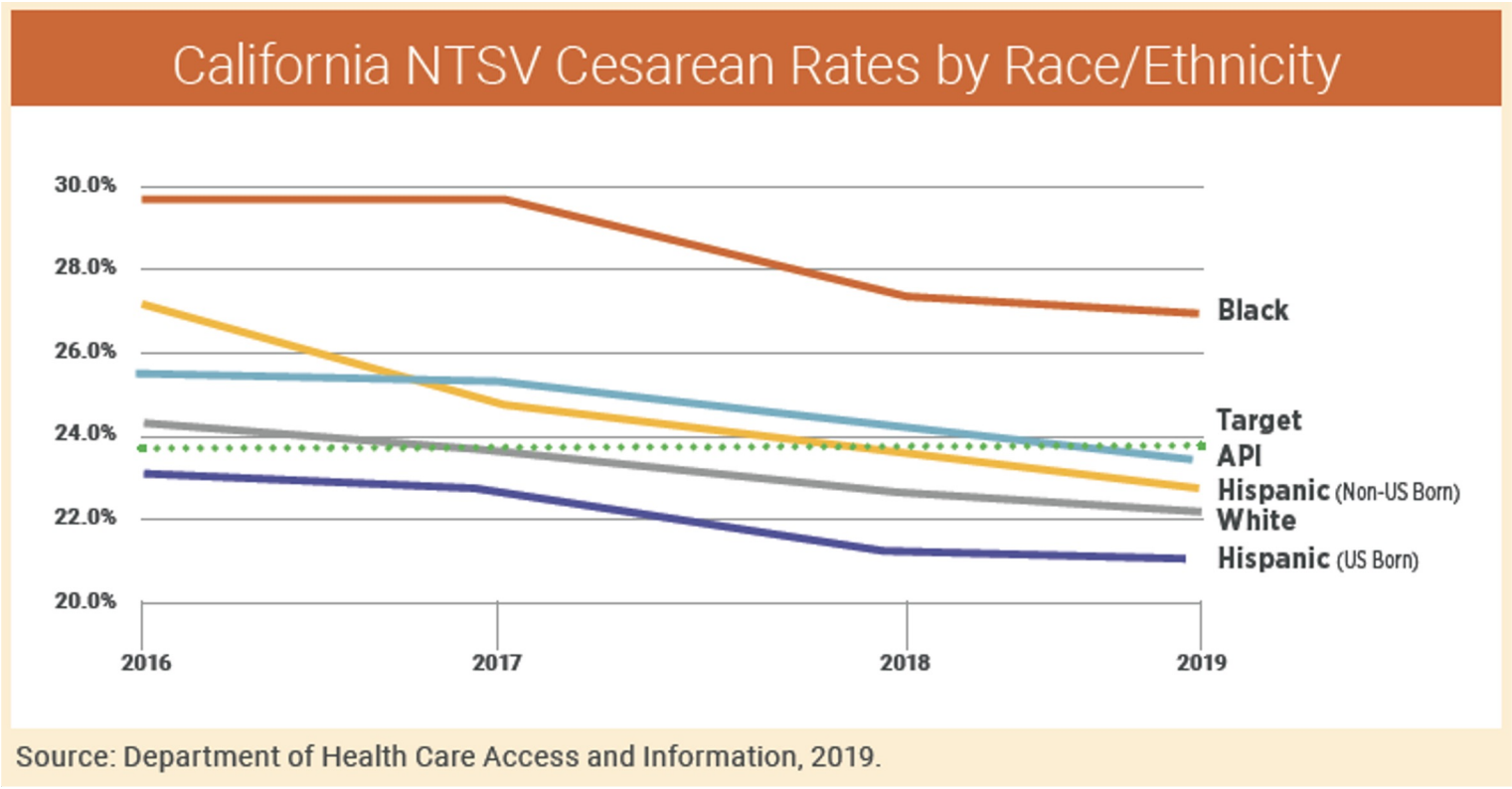

Image source: CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Birth Equity

Birth Equ·i·ty */noun/*

1. The assurance of the **conditions** of optimal births for all people with a **willingness** to address **racial and social inequalities** in a **sustained** effort.

- Aspirational
- Constant gardening (no one-offs)
- Emotional Intelligence
- Radical Empathy
- Innovative thinking
- Deconstructing harmful power centers
- Systems change
- Consider upstream social determinants of health
- Deal with health-related social needs
- Requires us to break our bias and destigmatize
- Trauma-informed

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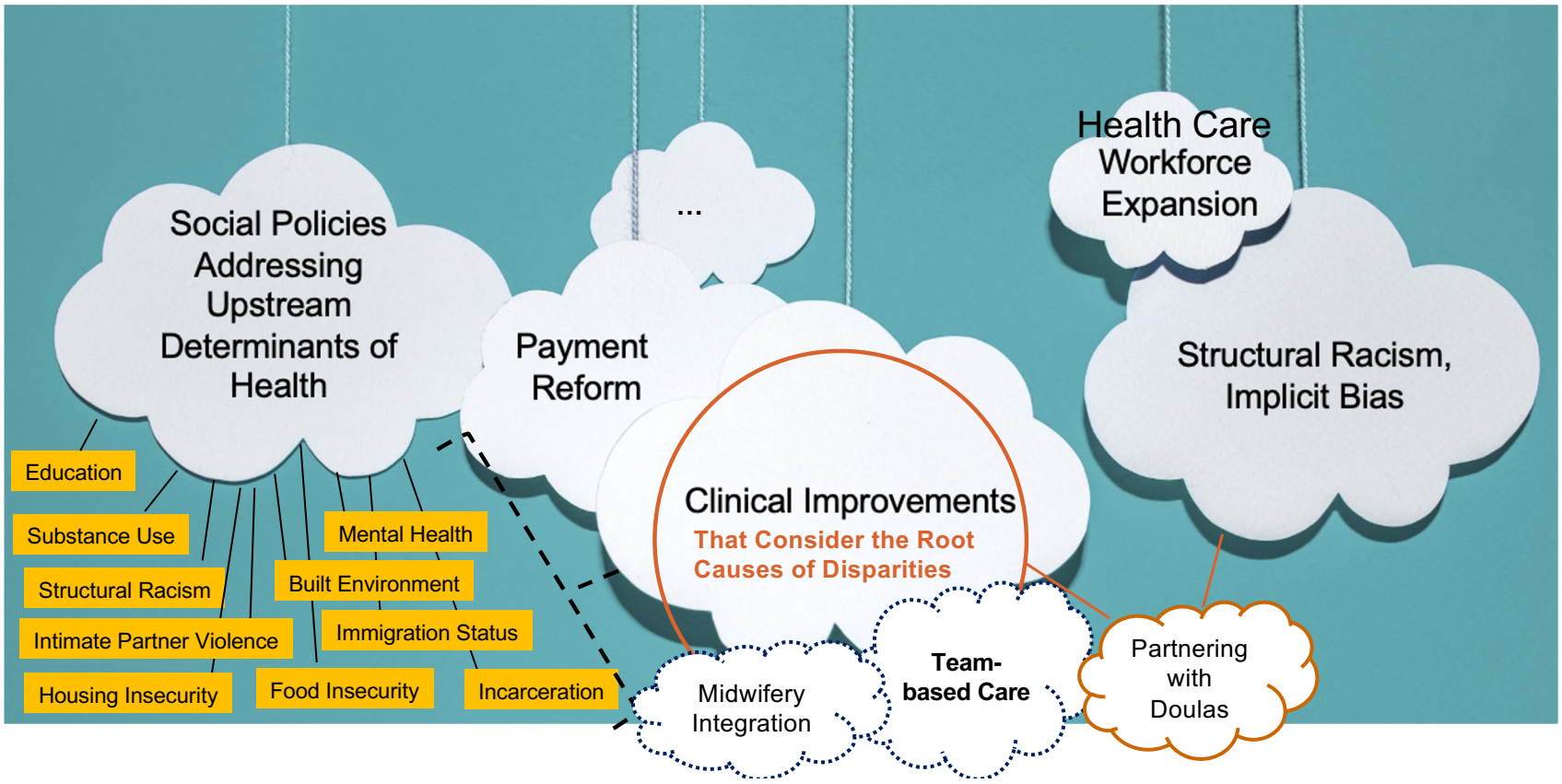
Typical Clinical Quality Improvement Efforts

Outcome-oriented
Cookie Cutter processes
Concrete measurable data sets
Target goals that are "good enough"
Low-hanging fruit
Start and stop
Behavior change but not hearts and minds

The Work Must Be Intentional…

- Utilize strategies that consider the root causes of disparities
- Consider community needs/wants in our approaches to quality improvement (patient and community-centeredness)
- Incorporate improvement measures that evaluate respect, dignity, and implicit bias in childbirth
- Humility to accept that what we are doing right now isn't working for everyone
- Use all the tools in the toolbox, not just the easy low-hanging strategies

Maternity Care Improvement Ecosystem



The Joint Commission

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Eliminating racial and ethnic disparities causing mortality and morbidity in pregnant and postpartum patients

Sentinel Event Alert

A complimentary publication of The Joint Commission — Issue 66, Jan. 17, 2023

Eliminating racial and ethnic disparities causing mortality and morbidity in pregnant and postpartum patients

Editor's Note: In June 2022, the White House issued a report stating that the United States is facing a maternal health crisis.[1] The Joint Commission has been actively working to help address the myriad and complex causes of maternal mortality and morbidity. This Sentinel Event Alert *delves into eliminating barriers and racial disparities causing mortality and morbidity in pregnant and postpartum patients. In addition, The Joint Commission is issuing a Quick Safety that addresses mental health conditions and their role in maternal death.*

Black tennis star Serena Williams faced life-threatening complications five years ago while giving birth to her daughter in an emergency cesarean section.[2] In a recently published book, "Arrival Stories: Women Share Their Experiences of Becoming Mothers," Williams writes, "Giving birth to my baby, it turned out, was a test for how loud and how often I would have to call out before I was finally heard." Her essay describes the complications she faced and how she needed to insist repeatedly while in labor for treatment appropriate for her history of blood clots in her lungs. The dismissal of symptoms and the tendency not to respond to a patient's concerns commonly leads to a sentinel event. In Serena's case, she was fortunate that her complications were eventually treated, and a sentinel event was avoided. Williams now serves as an advocate for maternal health care.

Higher pregnancy-related mortality and morbidity rates for people of color demonstrate how racial and ethnic disparities are quality and patient safety issues. Data show that:

- Non-Hispanic Black people are three times more likely than white people to die of pregnancy-related causes, according to the Centers for Disease Control and Prevention (CDC).[3]
- Native American pregnant patients are twice as likely to die than white pregnant patients.[4]
- For Black and Native American people over the age of 30, mortality for pregnancy-related causes is four to five times higher than it is for white people.[4]
- For Black pregnant patients with at least a college degree, the mortality rate is 5.2 times higher than that of their white counterparts.[4]

The United States has the highest mortality rate for pregnant and postpartum patients among developed countries. According to the CDC's National Center for Health Statistics,[5] that rate increased by 18% in 2020 – from 20.1 deaths per 100,000 live births in 2019 to 23.8 in 2020. In 2020, 861 pregnant or postpartum patients died from pregnancy-related causes in the U.S. compared to 754 in 2019. A prepandemic report from Maternal Mortality Review Committees conducting a thorough review of pregnancy-related deaths in 36 U.S. states determined that 80% of them were preventable.[6]

By race, pregnancy-related mortality rates are 55.3 per 100,000 live births for non-Hispanic Black people, 19.1 for non-Hispanic white people, and 18.2 for Hispanic people.[5] This racial and ethnic disparity in mortality rates may be due to several factors such as structural racism, implicit biases, and their impact on access to care, quality of care, and prevalence of chronic diseases.[7,8] The COVID-19 pandemic exacerbated racial disparities in pregnancy-related outcomes. During 2020, the rate of death for Black and Hispanic pregnant or postpartum patients rose significantly, while the rates for their white counterparts rose only slightly.[5]

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high-risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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The Joint Commission

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3. Provide support and options that meet the needs and expectations of patients, including those who wish to deliver in a home or birthing center environment, while managing their risk of pregnancy complications. The pregnant patient and the clinician should share decision-making. Discuss delivery options and support patients in receiving their preferences. To reduce the high incidence of low-risk C-sections, provide education and training for the interdisciplinary team to develop knowledge and skills on approaches that maximize the likelihood of a vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and nonpharmacologic), and shared decision making.

Doulas as Essential Changemakers in Birth Outcomes

"Published data indicate that one of **the most effective tools** to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula… Given that there are no associated measurable harms, this resource is probably underutilized."

– ACOG/SMFM Obstetric Care Consensus on the Safe Prevention of Primary Cesarean Delivery

MARCH OF DIMES POSITION STATEMENT DOULAS AND BIRTH OUTCOMES

Summary and Purpose

Consistent with its mission to fight for the health of all moms and babies, March of Dimes issued a July 2018 Position Statement on Maternal Mortality and Morbidity, released a report on maternity care deserts, and is developing an approach to address the "poor quality and differential care" that contributes to the higher rates of maternal morbidity and mortality experienced by women of color.[1] This interim Position Statement on Doulas and Birth Outcomes will be part of a broader March of Dimes approach to these issues that is under development. It provides evidence and guidance to support March of Dimes participation in advocacy efforts related to doula care as they arise nationally and locally. It also can serve as an education tool about the importance of doulas as a part of the birth team.

In summary, this document states that:

- March of Dimes supports increased access to doula care as one tool to help improve birth outcomes and reduce the higher rates of maternal morbidity and mortality among women of color in the United States.
- March of Dimes advocates for all payers to provide coverage for doula services.
- March of Dimes recognizes the importance of increased training, support and capacity development for doulas, including doulas from racially, ethnically, socioeconomically and culturally diverse communities.

Introduction

Doulas are non-clinical professionals who provide physical, emotional and informational support to mothers before, during and after childbirth, including continuous labor support.[2] Six percent of birthing women in the U.S. said they used a doula during childbirth in a 2012 survey.[3] While there is no reliable estimate of the number of doulas in the U.S., a centralized online doula registration service, not affiliated with any one certifying organization, had 9,000 registered doulas in 2018.[4]

Studies suggest that increased access to doula care, especially in under-resourced communities, can improve a range of health outcomes for mothers and babies, lower healthcare costs, reduce c-sections (cesarean sections), decrease maternal anxiety and depression, and help improve communication between low-income, racially/ethnically diverse pregnant women and their health care providers.

The role of doula care in reducing c-sections is important, because c-sections contribute to the risk of maternal morbidity and mortality in initial and subsequent pregnancies. March of Dimes supports increased access to doula care as one tool to help improve birth outcomes and reduce the higher rates of maternal morbidity and mortality among women of color in the United States.

Doula support is not routinely covered by health insurance. Since one of the barriers to having doula support is cost, insurance coverage for doula support through Medicaid, the Children's

Improving Our Maternity Care Now Through *Doula Support*

HealthConnect One · Health Law · national partnership for women & families

Community-Based Doulas and Midwives

Key to Addressing the U.S. Maternal Health Crisis

By Nora Ellmann April 2020

WWW.AMERICANPROGRESS.ORG

ADVANCING BIRTH JUSTICE:

Community-Based Doula Models as a Standard of Care for Ending Racial Disparities

ANCIENT SONG DOULA SERVICES
VILLAGE BIRTH INTERNATIONAL
EVERY MOTHER COUNTS

Asteir Bey
Aimee Brill
Chanel Porchia-Albert
Melissa Gradilla
Nan Strauss

March 25, 2019

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 766 *(Replaces Committee Opinion No. 687, February 2017)*

Committee on Obstetric Practice

The American College of Nurse-Midwives endorses this document. This Committee Opinion was developed by the Committee on Obstetric Practice in collaboration with committee members Allison S. Bryant, MD, MPH and Ann E. Borders, MD, MSc, MPH.

Approaches to Limit Intervention During Labor and Birth

ABSTRACT: Obstetrician–gynecologists, in collaboration with midwives, nurses, patients, and those who support them in labor, can help women meet their goals for labor and birth by using techniques that require minimal interventions and have high rates of patient satisfaction. Many common obstetric practices are of limited or uncertain benefit for low-risk women in spontaneous labor. For women who are in latent labor and are not admitted to the labor unit, a process of shared decision making is recommended to create a plan for self-care activities and coping techniques. Admission during the latent phase of labor may be necessary for a variety of reasons, including pain management or maternal fatigue. [illegible] to regular nursing care, continuous one-to-one emotional support provided by support [illegible]ciated with improved outcomes for women in labor. Data suggest that for women with [illegible]o evidence of fetal compromise, routine amniotomy need not be undertaken unless [illegible]he widespread use of continuous electronic fetal monitoring has not been shown to [illegible] as perinatal death and cerebral palsy when used for women with low-risk pregnancies. [illegible]armacologic techniques can be used to help women cope with labor pain. Women in [illegible]may not require routine continuous infusion of intravenous fluids. For most women, no [illegible]d or proscribed. Obstetrician–gynecologists and other obstetric care providers should be [illegible]w-interventional approaches, when appropriate, for the intrapartum management of low- [illegible]r. Birthing units should carefully consider adding family-centric interventions that are [illegible]routine care and that can be safely offered, given available environmental resources and [illegible]ntric interventions should be provided in recognition of the value of inclusion in the [illegible]n and their families, irrespective of delivery mode. This Committee Opinion has been [illegible]ce for risks and benefits of several of these techniques and, given the growing interest [illegible]ation on a family-centered approach to cesarean birth.

Conclusions

[illegible]tricians and Gynecolo- [illegible]wing recommendations

[illegible]n in spontaneous labor [illegible]tion, labor management [illegible]nding on maternal and [illegible]include techniques such [illegible]and nonpharmacologic

- Admission to labor and delivery may be delayed for women in the latent phase of labor when their status and their fetuses' status are reassuring. The women can be offered frequent contact and support, as well as nonpharmacologic pain management measures.
- When women are observed or admitted for pain or fatigue in latent labor, techniques such as education and support, oral hydration, positions of comfort, and nonpharmacologic pain management techniques such as massage or water immersion may be beneficial.

[illegible]RY 2019 OBSTETRICS & GYNECOLOGY

Doulas Have Been Present Throughout History

Various Historical Depictions of Birth with Labor Support

What is a Doula?

- A doula is a trained, non-medical professional who supports and protects the patients physical, emotional, and informational needs during labor
- Doulas also have an important teaching and advocacy role during pregnancy, labor, and **postpartum**
- Some doulas provide support during/after miscarriage or abortion
- There are even “end-of-life doulas” who support people in hospice or other times as they prepare for end-of-life

Four Key Roles for Doulas

- They **provide information** about childbirth and foster communication between birthing women and people and members of the care team.
- They **play an advocacy role**, helping birthing women and people to achieve their desired experiences.
- They **provide practical support**, through drug-free comfort measures (e.g., with inflatable "birth balls," hot and cold packs, and position changes) and hands-on support (e.g., massage and acupressure).
- They **provide emotional support** for confidence and a sense of control.[13]

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Toolkit Resources: Elements of Doula Care

What Doulas Do

- **Teaching**
  - Prenatal teaching & childbirth ed; lactation and infant feeding
- **Physical comfort care and support**
  - Labor support and coping
  - Support for epidural & comfort care for breakthrough pain
  - Patient positioning to assist fetal descent and rotation
  - Typically remain with the patient throughout labor & "Golden Hour"
- **Patient Advocacy**
  - Bridge between patient and providers
  - Culturally congruent advocacy & informational assistance
  - Preserve & support respectful care, privacy, and dignity
  - Connection to social resources
- **Postpartum Support and Connections to Care**
  - Lactation during "Golden Hour;" infant feeding & care
  - Recognition of postpartum symptoms that need attention
  - Connection to social resources as needed

What Doulas Do Not Do

- **Provide clinical or nursing care**
  - Physical assessments
  - Catching the baby
  - Fetal monitoring
  - Medication administration
- **Diagnose or give medical advice**
- **Make decisions for the patient or pressure the patient into certain decisions**
- **Leave the patient during labor**

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Benefits of Doula Care

Less likely with a doula...	More likely with a doula...
• Cesarean birth • Operative vaginal birth • Need for oxytocin • Epidural anesthesia • Use of pain medication	• Spontaneous vaginal birth • Shorter labor • Higher APGAR scores • Breastfeeding initiation • Patient-centered care • Positive birth experience • Lower cost

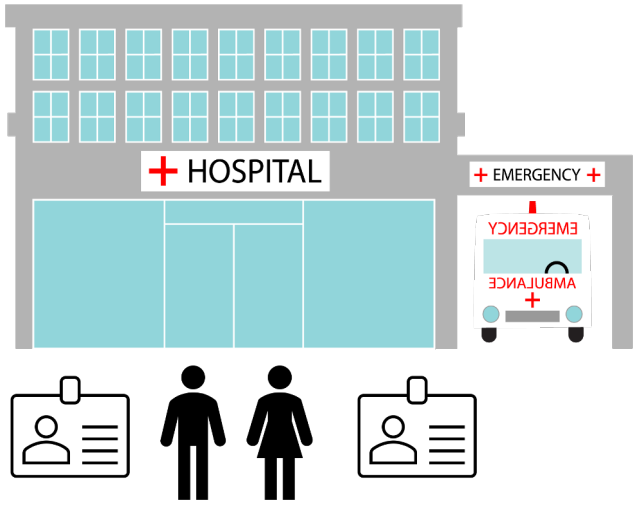
"In comparison with women receiving no continuous labor support, women with doula support were an impressive 39 percent less likely to have a cesarean birth"[444]

Image source: CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Quote Source: Continuous Support for Women During Childbirth: 2017 Cochrane Review Update Key Takeaways. J Perinat Educ. Oct 2018;27(4):193-197. doi:10.1891/1058-1243.27.4.193

Toolkit Resources: Types of Doula Programs

Hospital-Based Doulas



Community Doulas and Doula Collectives

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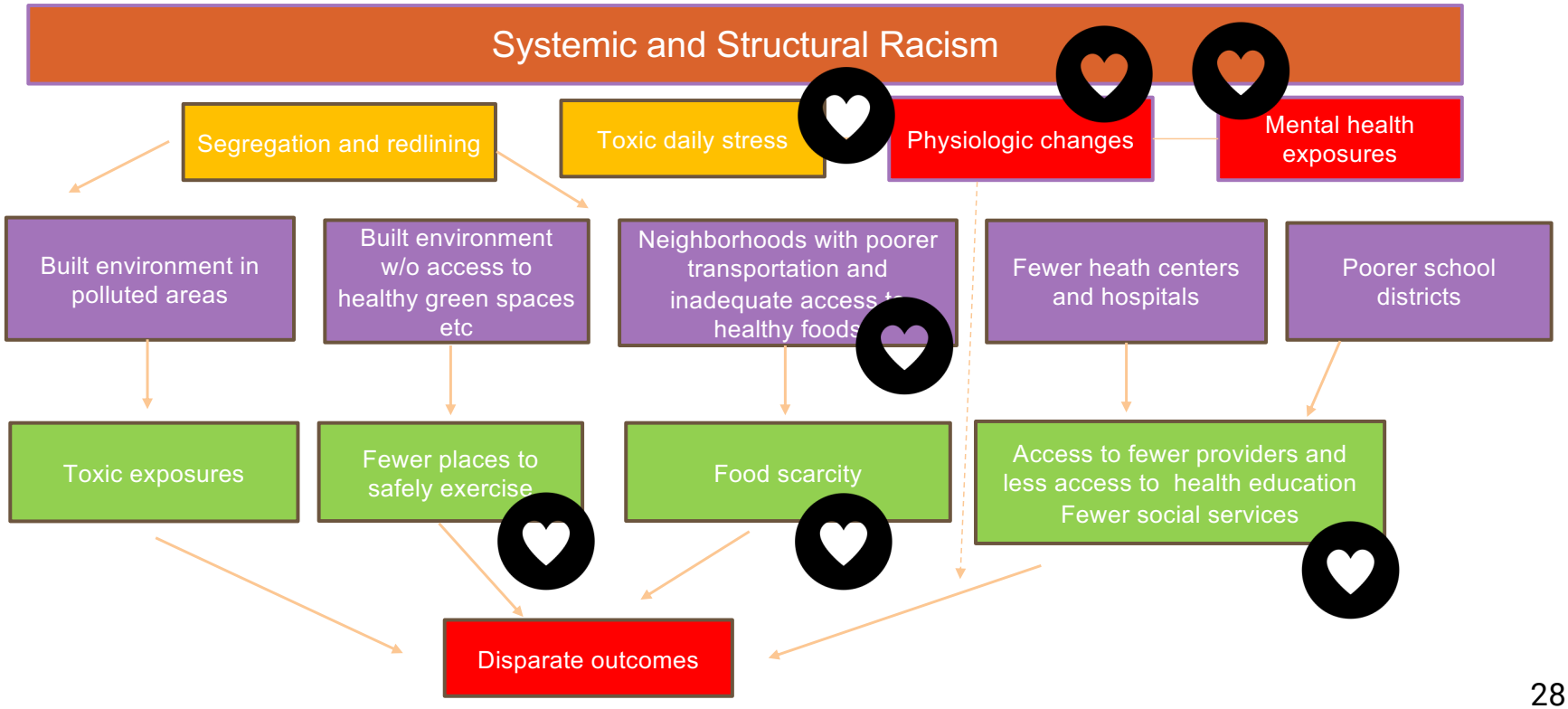
Understanding Systemic Racism and Disparate Birth Outcomes is Critical to Understanding Community Doulas in Modern Times



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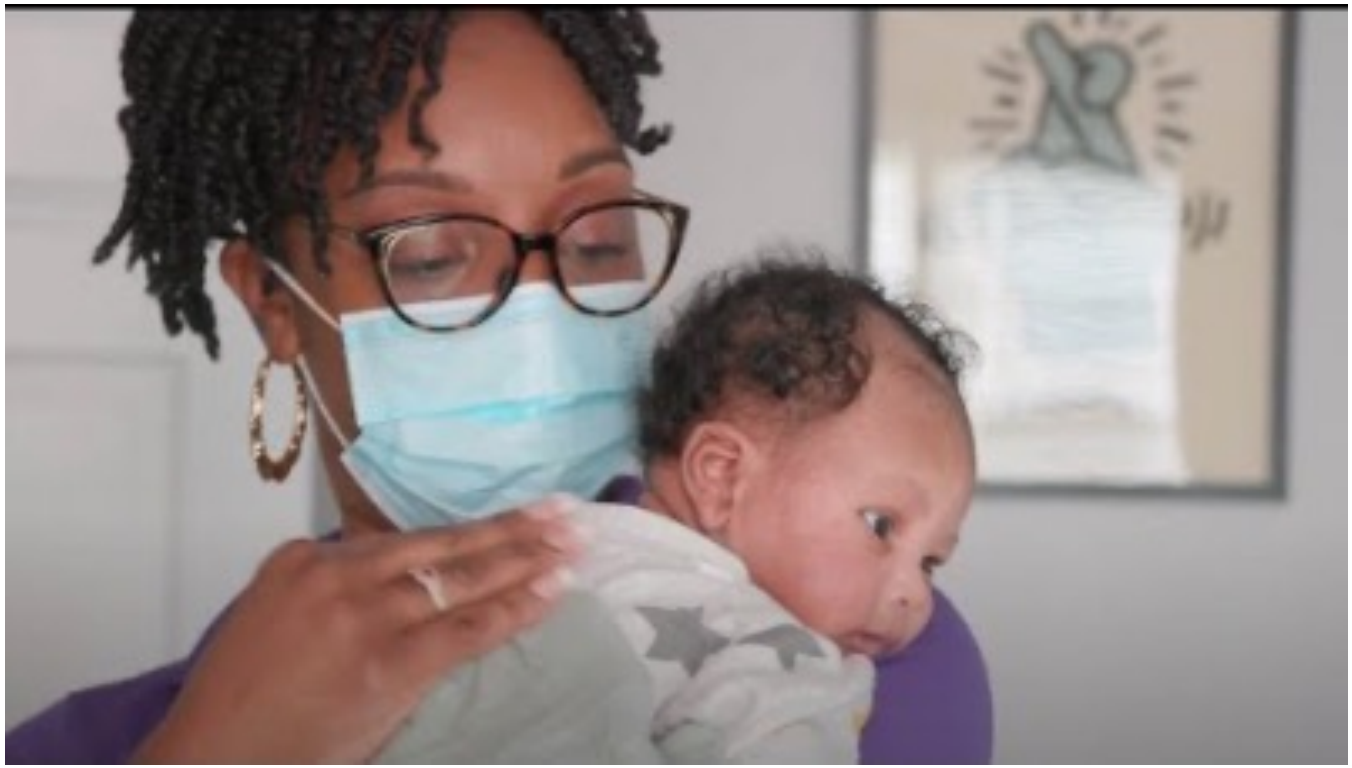
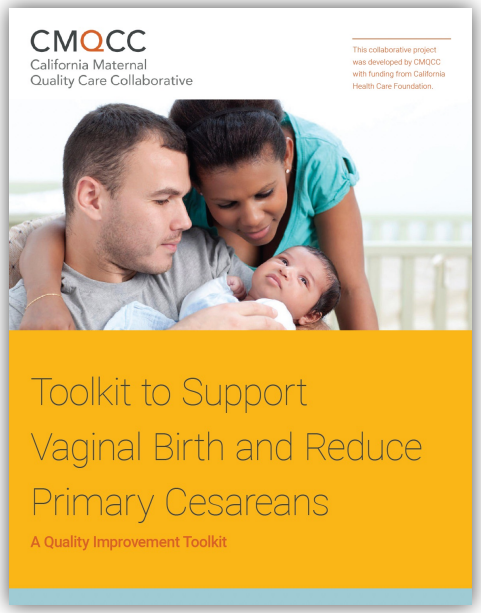


Toolkit Strategies for Partnering with Doulas

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Key Strategies for Integrating Doulas Into the Birth Care Team

1 Administrative Strategies

- Foster a departmental culture that values physiologic birth and reduced intervention for normal, low-risk birthing people
- Work together with local doula organizations to provide consistent, accessible support and resources to families
- Connect with community-based doula programs and show interest in supporting and welcoming community-based doulas at your facility
- Explore the feasibility of establishing a hospital-based doula program at your facility that prioritizes a doula workforce that reflects the community being served
- Even if your hospital already has a doula program, do not prevent or restrict the ability of patients to bring their own doula
- All doulas – whether community-based or hospital volunteers – should be empowered to remain independent champions for patients
- Hospital policies should reflect that doulas are not "visitors" in the traditional sense (specifically, they should not bound by time limits or other visitor rules that would restrict their ability to remain with the patient)

2 Clinical Strategies

- Intentionally cultivate a culture on the birthing unit that values physiologic birth through the standardization of clinical practices such as intermittent auscultation, mobility in labor, continuous labor support, and preserving the patient-baby dyad. Resources include:
  - Section II of this toolkit
  - ACNM's Pearls of Physiologic Birth
  - ACOG's Approaches to Limit Intervention During Labor and Birth
- Understand and value the doula's extensive knowledge of labor support techniques as a complement to technical and medical skill sets
- Establish expectations for how providers, nurses, and doulas interact and support each other, and consistently model collegial rapport and open communication
- Develop unit guidelines or educational materials that delineate a mutual understanding of roles and invite local doulas to help create these materials
  - Share these materials with nurses and providers and invite local community groups to share the materials widely with other doulas and patients
  - For facilities with hospital-based doula programs, posting this information at the bedside may help patients to understand the role of their doula
- Foster a culture of patient-centered care that values shared decision making and autonomy and the understanding that doulas are there to consistently advocate on behalf of the patient
- Engage in mutual learning at the time of clinical interaction. Doulas and nurses can learn an enormous amount from each other, and patients also benefit from this shared interaction
  - Some doulas desire to learn more about the medical and nursing aspects of labor
  - Doulas can teach evidence-based, culturally informed techniques that are not often taught in traditional medical and nursing training
- Update policies to include doulas as support people in the operating room if the patient desires

3 Educational Strategies

- Department educational opportunities should include a deeper dive into the components and strategies for successful team-based care that incorporate doulas as part of the team
- Create expanded opportunities for department-wide, interprofessional education that includes doulas from your community or a doula organization with whom you have a relationship
- Debrief about – and learn from – normal, physiologic birth where doula care was, or could have been, pivotal in the patient's progress and outcome
- Ensure that provider and nursing education includes racism-based disparities in maternity care, implicit bias, and an understanding of the role of doula care in curbing this trend

- Administrative Strategies
- Clinical Strategies
- Educational Strategies

Toolkit Strategies for Partnering with Doulas (continued)

- ✓ Doulas at your facility are empowered to remain independent champions for patients
- ✓ Policies reflect that doulas are not “visitors” bound by time limits or other visitor rules
- ✓ Updated policies to include doulas as support people in the operating room
- ✓ Intentionally cultivating a culture on the birthing unit that values physiologic birth and patient choice
- ✓ Connect to community-based doula programs & welcome community-based doulas at your facility
- ✓ Creating opportunities for interprofessional education that includes doulas from your community or a doula organization with whom you have forged a relationship

*More strategies in toolkit!

Doulas are Part of the Team

- An integral part of supportive care for the patient
- Same goal – same team!
- Because the patient says so

Doulas in California

- Medi-Cal – doula benefit
- Various pilot projects and doula research
- Community doula programs across the state
- Growing popularity of hospital programs

Amazing Resource! NHeLP Doula Medicaid Project Website

ALL PREGNANT AND POSTPARTUM PEOPLE DESERVE ACCES TO FULL SPECTRUM DOULA CARE.

NATIONAL HEALTH LAW PROGRAM

https://healthlaw.org/doulamedicaidproject/

California Doula Pilots Lessons Learned Project

From October to November 2021, the National Health Law Program's Doula Medicaid Project conducted interviews with doulas, fur
administrative staff involved with at least ten doula pilot programs in California with a primary focus on addressing racial health disp
particular on providing free doula services to either Black pregnant and birthing people or Medicaid enrollees. Overall, we found th
share remarkable consistency across some broader themes. At the same time, on a more granular level, the doula pilots have beer
from one another, with different funding structures, scope of care provided, recruitment plans, training requirements, etc. On Janua
Doula Medicaid Project held a panel discussion with representatives from six of the interviewed doula pilot programs.

What follows are a set of publications and resources that we have created from our interviews, conversations, and panel discussion. We hope that in compiling and sharing out th
experience and expertise of those involved in these doula pilots can help to inform the rollout and implementation of California's statewide doula Medicaid benefit. We also hope
can be helpful for doulas and advocates in other states across the country who are setting up similar doula pilot programs or expansions of doula care in their own regions.

- Summaries of California Doula Pilot Programs
- Challenges Reported by California Doula Pilot Programs
- Lessons Learned from California Doula Pilot Programs
- [WATCH] Doulas Know Best – Lessons Learned from California's Doula Pilot Programs Panel Discussion
- [WATCH] Time-lapse of Visual Recording by Ashanti Gardner
- [View] Visual Recording by visual scribe Ashanti Gardner
- Q&A from Doulas Know Best

Access the Project

Doula Benefit Orientation
2-Part Series
Sept 7: Basics
Sept 14: Deep Dive

Other Resources

- CMQCC Webinar

Incorporating Doulas into Your Hospital

- CMQCC Webinar

UCSD Volunteer Doula Program: A Model for Integration in a Hospital Setting

- YouTube video UCSD Volunteer Doula Program

Final Webinar in This Series!

Community Birth - Improving Transfer of Care

Oct 25, 2023

12pm-130pm

Photo by Rebekah Vos on Unsplash

CMQCC Clinical Leads and Data Center

Data questions

- datacenter@cmqcc.org

Clinical improvement questions or questions about toolkit

- csakowski@cmqcc.org

Questions about midwifery integration and doula care

- holly@midwiferyrising.org

Panelist Discussion

References

- Smith H, Peterson N, Lagrew D, Main E. 2016. Part V. *Toolkit to Support Vaginal Birth and Reduce Primary Cesareans: A Quality Improvement Toolkit*. Stanford, CA: California Maternal Quality Care Collaborative.

- Specific references available upon request
- References for Part V of the *Toolkit to Support Vaginal Birth* begin on page 188, starting with reference #339