TeamBirth: Pathway to Achieving Equitable Care
1. Ariadne & Delivery Decisions Initiative Introduction
2. Quality Improvement
3. TeamBirth
4. TeamBirth PREM’s Research
5. Oklahoma Leading
6. Questions + Additional Resources
OUR VISION is a world in which every person can choose to grow their family with dignity.
MEET THE DDI TEAM

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Misha Severson, RN: Implementation Specialist

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Lindsey Renner: Research Assistant

Tyler Fox: Project Assistant
We are a joint center for health systems innovation at Brigham & Women’s Hospital and the Harvard T.H. Chan School of Public Health

Our vision and mission are more necessary than ever.
Our mission is to **save lives** and **reduce suffering** for people everywhere, by creating scalable systems-level solutions that improve health care.
The last century of scientific research has driven incredible **breakthrough innovations** in medicine and public health.
Yet millions worldwide face needless suffering due to breakdowns in the systems that deliver care.
We have the breakthroughs to save countless lives around the world.

We need follow-through innovations to close gaps that prevent these innovations from reaching every patient, everywhere.
Gaps between what we know should be done, and what actually occurs in our health care and public health systems.

WE CALL THESE SYSTEMIC BREAKDOWNS “KNOW-DO” GAPS
Gaps between what we know should be done, and what actually occurs …..in our real lives
Know-Do Gap
Surgical intervention in childbirth is designed to “rescue” mom and babies from harm. We see a 500% increase over 4 decades.
Countries with rates over 19% do not have better maternal and neonatal outcomes.

Cesarean rates vary greatly at the country-level globally. As soon as a country develops the capability to perform this surgery they tend to overshoot and go from underuse to overuse.
Cesarean rates in the US vary widely at the hospital-level indicating an opportunity to remove harmful variation.

The system was not designed to make “right” and “easy” well aligned.

We identified four common patient flow and nursing management challenges:

1. **Scheduling planned cases**
2. **Tracking patient flow**
3. **Monitoring bed and staff availability**
4. **Adjusting bed and staff availability**
Labor floor busyness was associated with a significant increase in the likelihood of interventions and adverse maternal health outcomes.
Over the past generation, People giving birth in America has become less SAFE

U.S. women have the highest rate of maternal mortality among high-income countries, and this rate is rising. These women are also more likely to experience severe maternal morbidity.

Black women experience 3-4x higher mortality rates.

American Indian/Alaska Native women experience 2-3x higher mortality rates.

80% of pregnancy-related deaths were preventable.
Maternal mortality increased again in 2020

1Statistically significant increase in rate from previous year (p < 0.05).

NOTE: Race groups are single race.


The Last Person You'd Expect to Die in Childbirth

The U.S. has the worst rate of maternal deaths in the developed world, and 60 percent are preventable. The death of Lataria Bloomstein, a maternal nurse, in the hospital where she worked illustrates a profound disparity. Her death comes as the health care system in the U.S. becomes less focused on babies born of our own mothers than their mothers.

By Mireya Bacterio, Nathalie Augereau, and Sarah Elshamy, HMN
April 5, 2017

A NEONATAL INTENSIVE CARE NURSE, Lataria Bloomstein had been a symbol of what people's bodies can do for years.

Finally, at 34, she was ready to have her own: her 3-year-old baby girl had just arrived. She had a cesarean section and was in the hospital on a high level of care.

Lataria lived with her older brother for a while, then with a neighbor who helped her raise her daughter. She was in a nursing home when her brother died of a massive heart attack. Lataria had lived with her mother for a while, then with a neighbor who helped her raise her daughter. She was in a nursing home when her brother died of a massive heart attack. Theayer was in a nursing home when her brother died of a massive heart attack.

LUKE LONSDALE

Let me be clear: EVERY mother, regardless of race, or background deserves to have a healthy pregnancy and childbirth.

SERENA WILLIAMS

AFTERSHOCK ORIGINAL DOCUMENTARY PREMIERES JULY 19 hulu

DEAR DOULA

I'M A BLACK WOMAN, AND I'M SCARED OF DYING IN CHILDBIRTH

READ A DOULA'S RESPONSE

LOST MOTHERS

‘If You Hemorrhage, Don’t Clean Up’: Advice From Mothers Who Almost Died

We heard from 400 women who survived the hellish experience of giving birth or childbirth. They told us what they wish they had known—and what they wish someone had told them.

By D'Amico, Debola and Matthew Pulver and Sara Horowitz, HMN

April 3, 2017

Lyster

DS

PROPUBLICA

Graphics & Data 
Newsletters 
About

January 04, 2016

MIREYA BACTERIO

NATANIE AUGEREAU

SARAH ELSHAMY

PROPUBLICA GRAPHIC DESIGNERS

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In a national survey, almost 1/3 of women who gave birth in a hospital reported experiencing one or more types of mistreatment, such as loss of autonomy or receiving no response to requests for help.

Mistreatment is experienced more frequently by women of color and among those with social, economic or health challenges.

30% of Black and Hispanic primiparous women and 21% of White women who delivered in hospitals in the US reported that they were “treated poorly because of a difference of opinion with [their] caregivers about the right care for [herself or her] baby”
80-90% of reported sentinel events are due to failures of communication and teamwork.
Quality Improvement
Inequality
Unequal access to opportunities

Equality?
Evenly distributed tools and assistance
Health equity is achieved when everyone can attain their full potential for health and well-being. (WHO)
Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations.
- CMS
Standardization is equality. Individualized care is the critical for equity.
TeamBirth Purpose

TeamBirth is a care process innovation involving a series of team huddles between the patient and their care team, designed to empower each team member to contribute information, reliably structure communication, and help the team arrive at shared plans together.

> For patients, TeamBirth invites them into the conversations and provides a structure that is easy to understand and participate in.

> For clinicians, TeamBirth encourages all conversations to be had with the patient to promote effective team communication and alignment across the full team.
The tools and processes of the TeamBirth solution embody two design principles:

**Teamwork:** Promote psychological safety and shared decision-making with the birthing person

**Simplicity:** Reliably communicate information across the full care team, including the birthing person

And promote four core behaviors:

1. Promoting each member of the team
2. Eliciting patient preferences
3. Distinguishing plan for patient, baby, and labor progress
4. Setting clear expectations for next huddle
TeamBirth Core Components:

1. Team Huddles
2. Shared Planning Board

Components which are critical to successful delivery of the intervention
1. TeamBirth Huddles

WHO

The full direct care team, including the person in labor and their support

WHAT

Discuss preferences; care plans for mom, baby, and labor progress; and expectations for the next huddle

WHEN

At admission, major decision points or changes in care plans throughout labor and postpartum

WHY

Give all team members the opportunity to participate in shared decision-making
2. Shared Planning Board

A dry-erase board that is divided into quadrants - each corresponding to one of the 4 core behaviors - is used to structure the discussion during team huddles and provide a shared mental model of this information for all members of the care team.
Hospitals are supported in designing a board that meets their own needs and desires, while remaining true to the TeamBirth core components.

<table>
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<tr>
<th>TEAM</th>
<th>PLAN</th>
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<th>PREFERENCES</th>
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<th>NOTES</th>
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<table>
<thead>
<tr>
<th>LABOR &amp; BIRTH PLANNING BOARD</th>
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<tbody>
<tr>
<td>ROOM#</td>
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<td>-------</td>
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<table>
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<tr>
<th>NEXT HUDDLE</th>
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<table>
<thead>
<tr>
<th>EARLY LABOR</th>
<th>ACTIVE LABOR</th>
<th>PUSHING</th>
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Decision aids are used to support huddles at key decision points, including admission and delivery. They are designed to be patient-facing and easily understandable.
TeamBirth Research
1. TeamBirth Design (July 2021)

The design of “TeamBirth”: A care process to improve communication and teamwork during labor

Reena Aggarwal MRCOG, MBBCr, MSc, BPharm, Avery Plough MPH, Natalie Heinrich PhD, MPH, Grace Galvin MPH, Amber Rucker BA, Chris Barnes BA, William Berry MD, MPA, MPH, Tari Golan MD, Neal T. Shah MD, MPP

First published: 09 July 2021 | https://doi.org/10.1111/birt.12566 | Citations: 1

The study was conducted by the Ariane Labs at Brigham and Women’s Hospital and the Harvard T. H. Chan School of Public Health, Boston, Massachusetts.

Funding Information:
The study was funded by the Peterson Center on Healthcare. The Peterson Center on Healthcare was not involved in the study design, the collection, analysis and interpretation of data, the writing of the report, or the decision to submit the article for publication.

Abstract

Background

Despite evidence that communication and teamwork are critical to patient safety, few care processes have been intentionally designed for this purpose in labor and delivery. The purpose of this project was to design an intrapartum care process that aims to improve communication and teamwork between clinicians and patients.

2. TeamBirth Primary Outcomes (March 2022)

Improving communication and teamwork during labor: A feasibility, acceptability, and safety study

Amber Wiestrich DNP, MSN, RN, Avery Plough MPH, Reena Aggarwal MRCOG, MBBCr, MSc, BPharm, Grace Galvin MPH, Amber Rucker BA, Natalie Heinrich PhD, MPH...

First published: 01 March 2022 | https://doi.org/10.1111/birt.12630

Clinical Trial Registration: ClinicalTrials.gov identifier: NCT03529214.

Funding Information:
This research was supported by a grant from the Peterson Center on Healthcare. The funding agency had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review or approval of the manuscript, and decision to submit the manuscript for publication.

Abstract

Background

TeamBirth was designed to promote best practices in shared decision-making (SDM) among care teams for people giving birth. Although leading health organizations recommend SDM to address gaps in quality of care, these recommendations are not consistently implemented in labor and delivery.

3. TeamBirth Implementation (Jan 2022)

Implementation strategies within a complex environment: A qualitative study of a shared decision-making intervention during childbirth

Lauren Spigel MPH, Avery Plough MPH, Victoria Paterson MPH, Rebecca West MPH, Amanda Jarczak MPH, Natalie Heinrich PhD, MPH, Susan Gullo RN, MS, Brett Corrigan BA...

First published: 07 January 2022 | https://doi.org/10.1111/birt.12611

Abstract

Background

Shared decision-making (SDM) may improve communication, teamwork, patient experience, respectful maternity care, and safety during childbirth. Despite these benefits, SDM is not widely implemented, and strategies for implementing SDM interventions are not well described. We assessed the acceptability and feasibility of TeamBirth, an SDM solution that centers the birthing person in decision-making through simple tools that structure communication among the care team. We identified and
TeamBirth Research: Birth Equity, Autonomy and Trust

Oklahoma Perinatal Quality Improvement Collaborative
- 3-year partnership
- Implementing in all 43 birthing hospitals
- 4 Cohorts

Participating hospitals
Patient Survey Data: Demographics

**Unpublished Data**

**Age: OPQIC Cohort 1, OSU, & Hillcrest Combined**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Under 20</td>
<td>7%</td>
</tr>
<tr>
<td>20-24</td>
<td>26%</td>
</tr>
<tr>
<td>25-29</td>
<td>31%</td>
</tr>
<tr>
<td>30-34</td>
<td>23%</td>
</tr>
<tr>
<td>35-39</td>
<td>11%</td>
</tr>
<tr>
<td>40 or Over</td>
<td>2%</td>
</tr>
</tbody>
</table>

*Data from 01/2021 - 11/13/2022

**Race/Ethnicity: OPQIC Cohort 1, OSU, & Hillcrest Combined**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>18%</td>
</tr>
<tr>
<td>NH AI/AN</td>
<td>8%</td>
</tr>
<tr>
<td>NH Asian</td>
<td>2%</td>
</tr>
<tr>
<td>NH Black/AA</td>
<td>10%</td>
</tr>
<tr>
<td>NH NH/PI</td>
<td>1%</td>
</tr>
<tr>
<td>NH Other</td>
<td>0%</td>
</tr>
<tr>
<td>NH White</td>
<td>51%</td>
</tr>
<tr>
<td>NH Multiracial</td>
<td>10%</td>
</tr>
</tbody>
</table>

*Data from 01/2021 - 11/13/2022

**Unpublished Data**
Patient Survey Data: Demographics

**Unpublished Data**

**Educational Attainment; OPQIC Cohort 1, OSU, & Hillcrest Combined**

- Some Elementary: 1% (n=17)
- Some High School: 11% (n=149)
- High School Graduate: 29% (n=408)
- Some College: 25% (n=351)
- College Degree: 24% (n=335)
- Some Postgraduate: 1% (n=20)
- Postgraduate Degree: 8% (n=117)

**Health Insurance; OPQIC Cohort 1, OSU, & Hillcrest Combined**

- Private: 33% (n=464)
- Medicaid: 49% (n=684)
- Indian Health Service: 0% (n=5)
- Other Government Program: 5% (n=70)
- Multiple Forms: 12% (n=163)
- No Coverage: 1% (n=11)

*Data from 01/2021 - 11/13/2022
Patient Survey Data: Demographics

First Baby; OPQIC Cohort 1, OSU, & Hillcrest Combined

- Yes: 34% (n=477)
- No: 66% (n=935)

Delivery Method; OPQIC Cohort 1, OSU, & Hillcrest Combined

- Vaginal: 75% (n=1060)
- Vaginal with Vacuum/Forceps: 3% (n=49)
- Cesarean: 21% (n=293)
- Multiple Methods: 1% (n=13)

*Data from 01/2021 - 11/13/2022

**Unpublished Data**
Patient Survey Data: Demographics

**Unpublished Data**

![Complications Chart]

Complications; OPQIC Cohort 1, OSU, & Hillcrest Combined

- Yes: 11% (n=150)
- No: 85% (n=1183)
- Don't Know: 4% (n=59)

*Data from 01/2021 - 11/13/2022*

![Hours on Labor and Delivery Chart]

Hours on Labor and Delivery; OPQIC Cohort 1, OSU, & Hillcrest Combined

- 0-4: 24% (n=330)
- 5-9: 25% (n=347)
- 10-14: 21% (n=269)
- 15-20: 12% (n=174)
- 21-24: 6% (n=89)
- 25+: 9% (n=128)
- Don't Know: 3% (n=39)

*Data from 01/2021 - 11/13/2022*
Patient Survey Data: TeamBirth Process Measures

**Unpublished Data**
Patient Survey Data: Mother’s Autonomy in Decision-Making (MADM) Measures

**Unpublished Data**
Patient Survey Data: Health Insurance by Labor Huddle

Health Insurance by Labor Huddle Status; OPQIC Cohort 1, OSU, & Hillcrest Combined

- Private: n=464
  - 19% No Huddle, 81% Yes Huddle

- Medicaid: n=684
  - 14% No Huddle, 86% Yes Huddle

- Other Government Program: n=70
  - 23% No Huddle, 77% Yes Huddle

- Multiple Forms: n=163
  - 18% No Huddle, 82% Yes Huddle

*Data from 01/2021 - 11/13/2022

**Unpublished Data**
The MADM and MORi - Measuring Respectful Care

● Developed by team of researchers at the Birth Place Lab (BPL) at the University of British Columbia to assess patient experiences with maternity care

● Community-based research: groups of people of childbearing age from a variety of cultural and socio-economic backgrounds
  ○ Women who have been incarcerated
  ○ Immigrants and refugees
  ○ Women who have experienced housing insecurity/homelessness and poverty
  ○ Communities of color
  ○ Women who planned community birth

● The MADM measures autonomy in decision-making, the MORi assess the nature of provider-patient relationships

● It is a reliable and validated tool (version 1.0 is most recent)

Mother’s Autonomy in Decision Making (MADM)

1. My doctor or midwife asked me how involved in decision making I wanted to be.
2. My doctor or midwife told me there are different options for my maternity care.
3. My doctor or midwife explained the advantages / disadvantages of the maternity care options.
4. My doctor or midwife helped me understand all the information
5. I was given enough time to thoroughly consider the different care options.
6. I was able to choose what I considered to be the best care options.
7. My doctor or midwife respected my choices.

**KEY**

**Level of Autonomy**
(by quartiles)

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Indication of Respect</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 - 15</td>
<td>Very Low Patient Autonomy</td>
</tr>
<tr>
<td>16 - 24</td>
<td>Low Patient Autonomy</td>
</tr>
<tr>
<td>25 - 33</td>
<td>Moderate Patient Autonomy</td>
</tr>
<tr>
<td>34 - 42</td>
<td>High Patient Autonomy</td>
</tr>
</tbody>
</table>
Patient Survey Data: MADM by Race/Ethnicity and Labor Huddle Status

MADM Quartiles by Health Insurance; OPQIC Cohort 1, OSU, & Hillcrest Combined

*Data from 01/2021 - 11/13/2022

**Unpublished Data**
Patient Survey Data: MADM Quartiles by Race/Ethnicity and Labor Huddle Status

MADM Quartiles by Race/Ethnicity and Labor Huddle Status; OPQIC Cohort 1, OSU, & Hillcrest Combined

**Unpublished Data**
Health Care Relationship Trust Scale HCRTS-R scale

- The Health Care Relationship Trust Scale is a validated tool that measures patient-providers trust which includes
  - interpersonal connection
  - respectful and honest communication
  - and knowledge sharing.

- The Revised scale consists of 13 questions.

- 5 point response format
  - 0 = none of the time
  - 1 = some or a little of the time
  - 2 = occasionally or a moderate amount of the time
  - 3 = most of the time
  - 4 = all of the time

  - Higher score = greater collaborative trust
1. How often does your health care provider discuss options and choices with you before health care decisions are made?
2. My health care provider is committed to providing the best care possible.
3. My health care provider is sincerely interested in me as a person.
4. My health care provider is an excellent listener.
5. My health care provider accepts me for who I am.
6. My health care provider tells me the complete truth about my health-related problems.
7. My health care provider treats me as an individual.
8. My health care provider makes me feel that I am worthy of his/her time and effort.
9. My health care provider takes the time to listen to me during each appointment.
10. I feel comfortable talking to my health care provider about my personal issues.
11. I feel better after seeing my health care provider.
12. How often do you think about changing to a new health care provider?
13. How often does your health care provider consider your need for privacy?
Patient Survey Data: Health Care Relationship Trust Scale Revised (HCRTS-R) Scores by Labor Huddle Status

HCRTS-R Scores (item 1-6): Percentage of Respondents Who Said "All the Time"
By Labor Huddle Status, OPQIC Only

My clinical team...

- **Discuss options and choices before making health care decisions**: 52% No Huddle, 75% Yes Huddle
- **Committed to providing best care possible**: 76% No Huddle, 93% Yes Huddle
- **Sincerely interested in me as a person**: 65% No Huddle, 86% Yes Huddle
- **Excellent at listening**: 70% No Huddle, 90% Yes Huddle
- **Accepted me for who I am**: 84% No Huddle, 95% Yes Huddle
- **Told me the complete truth about my health-related problems**: 77% No Huddle, 94% Yes Huddle

*Data from 05/2022 - 11/13/2022

**Unpublished Data**
Patient Survey Data: Health Care Relationship Trust Scale Revised (HCRTS-R) Scores by Labor Huddle Status (1/2)

HCRTS-R Scores items 7-13): Percentage of Respondents Who Said "All the Time"
By Labor Huddle Status, OPQIC Only

My clinical team...

<table>
<thead>
<tr>
<th>Item</th>
<th>No Huddle</th>
<th>Yes Huddle</th>
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<tbody>
<tr>
<td>Treated me as an individual</td>
<td>84%</td>
<td>94%</td>
</tr>
<tr>
<td>Made me feel that I am worthy of their time and effort</td>
<td>80%</td>
<td>93%</td>
</tr>
<tr>
<td>Took the time to listen to me during each huddle</td>
<td>70%</td>
<td>91%</td>
</tr>
<tr>
<td>Felt comfortable talking to my clinical team about my personal issues</td>
<td>72%</td>
<td>90%</td>
</tr>
<tr>
<td>Felt better after seeing my clinical team</td>
<td>73%</td>
<td>89%</td>
</tr>
<tr>
<td>Thought about asking to change at least one member of my clinical team</td>
<td>71%</td>
<td>83%</td>
</tr>
<tr>
<td>Considered my need for privacy</td>
<td>78%</td>
<td>90%</td>
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*Data from 05/2022 - 11/13/2022

**Unpublished Data**
Patient Survey Data: Net Promoter Score by Race/Ethnicity

Percentage Rating TeamBirth a "10" by Race/Ethnicity, OPQIC Only

- Hispanic: 83% (n=250)
- NH AI/AN: 74% (n=108)
- NH Asian: 75% (n=28)
- NH Black/AA: 90% (n=139)
- NH White: 82% (n=713)
- NH Multiracial: 75% (n=145)

*Data from 05/2022 - 11/13/2022

**Unpublished Data**
“... in postpartum care, [...] Night Shift did not really care to listen to what I had to say regarding what I was feeling. ____ [nurse] also did not want to give me any other options despite how me telling her how I was feeling. ____ [nurse] was very forceful instead of offering different solutions.

“The only improvements I would suggest is information about position alternatives and choices after being given an epidural and to get through labor. My team did an amazing job listening to me when I initiated the changes in position or ____ ____ ____ however if I was a patient unaware of those options I would love to have been presented with the information”
Patient Impact:

“The entire team ensured me and my son were well cared for before and after delivery. My doctor respected and supported my decision for my birth choice and safely delivered my son. The nurses and staff members who cared for me and my son after labor were exception and should be commended for their compassion, knowledge, and kindness.”

“The doctors, including the residents, were amazing in explaining things during my induction and listening to my concerns or questions. They truly made me feel heard and valued during my experience. Each labor nurse [...] was amazing, focusing solely on my needs and the health/safety of my delivery. postpartum nurses [...] made us feel extremely supported.”

**Unpublished Data**
Oklahoma Leading
By the end of 2022, TeamBirth will be implemented in 70 hospitals across the US, reaching over 250,000 births.

Atul Gawande develops surgical safety checklist, resulting in 50% mortality reduction.

Atul Gawande founds Ariadne Labs to develop scalable solutions to improve health delivery.

Ariadne’s Delivery Decisions Initiative launches TeamBirth across four pilot health systems serving 15,000 births per year.

TeamBirth wins $2M grant from Petersen Center to design and scale TeamBirth.

Secured contracts to implement and research TeamBirth across three health systems.

Developing partnerships.
TeamBirth Participating Hospitals 2022

Massachusetts:
- UMass Memorial
- UMass Health Alliance
- South Shore Hospital
- Baystate Franklin Medical Center
- Boston Medical Center
- Brigham & Women’s Hospital
- Cape Cod Hospital
- Fairview Hospital
- Mercy Medical Center
- Sturdy Memorial Hospital
- St. Vincent Hospital
- Tufts Medical Center

Michigan:
- Ascension River District Hospital
- Ascension Providence Hospital
- Ascension Providence Hospital
- Hurley Medical Center
- Mercy Health Hackley
- Michigan Medicine
- ProMedica Charles and Virginia Hickman Hospital
- ProMedica Coldwater Regional Hospital
- Sparrow Hospital
- St. Mary Mercy Livonia Hospital
- St. Joseph Mercy Ann Arbor Hospital

Ohio:
- Grant Medical Center
- Miami Valley Hospital
- Miami Valley South Hospital
- Akron Hospital

New Jersey:
- RWJ Copperman Barnabas
- RWJ Monmouth
- Virtua Hospital Voorhees
- Midwifery Birth & Wellness Center

California:
- Providence Santa Rosa

Oklahoma:
- Saint Francis Hospital
- OSU Medical Center
- Hillcrest Medical Center
- Ascension St. John Medical Center
- Bailey Medical Center
- Hillcrest Hospital Claremore
- Hillcrest Hospital South
- Mercy Hospital Oklahoma City
- Saint Francis Hospital Muskogee
- Saint Francis Hospital South
- St. Mary’s Regional Medical Center
- Ascension St John Owasso
- Ascension St John Jane Phillips
- Cherokee Nation WW Hastings Hospital
- Comanche County Memorial Hospital
- INTEGRIS Baptist Medical Center
- INTEGRIS Bass Baptist Health Center
- INTEGRIS Canadian Valley Hospital
- INTEGRIS Health Edmond
- INTEGRIS Miami Hospital
- McAlester Regional Medical Center
- SSM Health St Anthony Hospital OKC
- SSM Health St Anthony Hospital Shawnee
- Stillwater Medical Center

Tennessee:
- Baptist Women’s Health Center
- University of Tennessee Medical Center
TeamBirth Oklahoma continued…

1. Cohort 3 & 4
2. Education
3. Prenatal care
4. NICU
5. Digital
Education
Prenatal Tools

Being at the Center of Your Care Team During Your Birth
Birth is a team sport where you will be supported by your team of providers, nurses, and support people. You are at the center of this team, especially during huddles — it is your body and your birth.

What is a TeamBirth huddle?
TeamBirth huddles are times when your care team will all come together either in person or over the phone to give all members the opportunity to talk at key points in your care.

- **Who:** You and your provider(s), nurse(s), and support person(s)
- **What:** You and your care team will talk about your preferences, your care plans, and when you will huddle next
- **When:** At admission, for decisions or changes in the plan of care, or when any team member asks for one.

What role do all the team members have in huddles?
Your care will change as your labor goes on. Think about how your team can help you by sharing information or giving you support to feel good about the changes and decisions.

- Original design with clinicians, patients, public health professionals
- Co-designing testable version with Utica Park Nurse Practitioners
- Implementation and measurement at Tulsa clinics
- Q: Does prenatal education of increase a patient’s MADM score more than TeamBirth in the hospital alone.
Scaling TeamBirth: The State University of Zanzibar
Questions + Additional Resources
Learn more: 3 TeamBirth Manuscripts + Additional Resources


Use this QR code to access our 5-minute “Why TeamBirth?” video!