Person-Centered Decision Making and Place of Birth: Module Overview

In this introductory module, learners will explore the concept of Person-Centered Decision Making (PCDM) as it applies to maternity care. You will become familiar with the key steps that support person-centered decision making in practice. Through engagement with the unit material and activities, learners will also become familiar with availability of maternity care providers in the US, options for place of birth, and factors that influence birth site selection. This core content will allow each learner to approach the remaining modules within a common framework.

Learning Objectives

By the end of this module, participants will be able to:

1. Define Person-Centered Decision Making (PCDM) and describe a model for incorporating it into practice.
2. Discuss the context for maternity care in the United States (US).
3. Identify the options for people birthing in the US, including providers, their scope of practice and the limitation of services at each birth site.
4. Discuss factors that influence birth site selection, including patient preferences, and risk assessment.

What is Person-Centered Decision Making?

Person-Centered Decision Making is often referred to as a meeting between experts. Do you agree with this statement? What do you know about PCDM and how would you describe it?

There are a variety of definitions of PCDM. For example, some people relate it to concepts like patient/person-centered, informed decision making, enhanced autonomy, mutual participation (2).

We think this definition sums it up well:

> "Shared decision making (person-centered decision making) is a collaborative process that allows patients and their providers to make healthcare decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences."
>
> *Informed Medical Decisions Foundation* (8)

Why Does Person-Centered Decision Making Matter?

There is considerable evidence that engaging in a PCDM process is beneficial for both patients/clients and providers. Researchers have found that PCDM both improves health outcomes and reduces provider stress (1). People perceived they had better recovery from their discomfort or concern, better emotional health 2 months later, and a reduction of about 50% in rates of diagnostic tests and referrals (1). The most important association with good outcomes was the person's perception that all of the people involved had found common ground (1, 2). Providers report a sense of relief from sole responsibility and greater confidence in the care plan when they have engaged in a person-centered decision making process (2).

The healthcare conversation that is based on a Person-Centered Decision Making model (3, 4):

- Improves knowledge
- Increases overall engagement and empowerment
- Expands opportunity for agreement between care provider and person
- Increases satisfaction
- Reduces use of healthcare services
- Reduces costs
- Facilitates appropriate service use (e.g. major surgery versus low-intervention options)
- Better treatment adherence
- Augments confidence and coping skills
- Strengthens health behaviors

How does Person-Centered Decision Making Work?

There are a lot of different models for person-centered decision making. Some are used in the interprofessional context, some focus on the one-to-one clinical encounter, and other models include a third person that contributes to decision making. Here are two examples of different approaches to person-centered decision making:

The LEARN Model (9)

This model is a good example of a culturally sensitive approach to person-centered decision making.

L **Listen** with empathy and understanding to the client's perception of the problem.

Try questions like:
What do you think may be causing your problem?

How do you think the illness is affecting you?

What do you think might be beneficial?

E **Explain** your thoughts and perceptions about the problem.

A **Acknowledge** and discuss the difference and similarities. Incorporate both your client's belief and your professional beliefs in the treatment options.

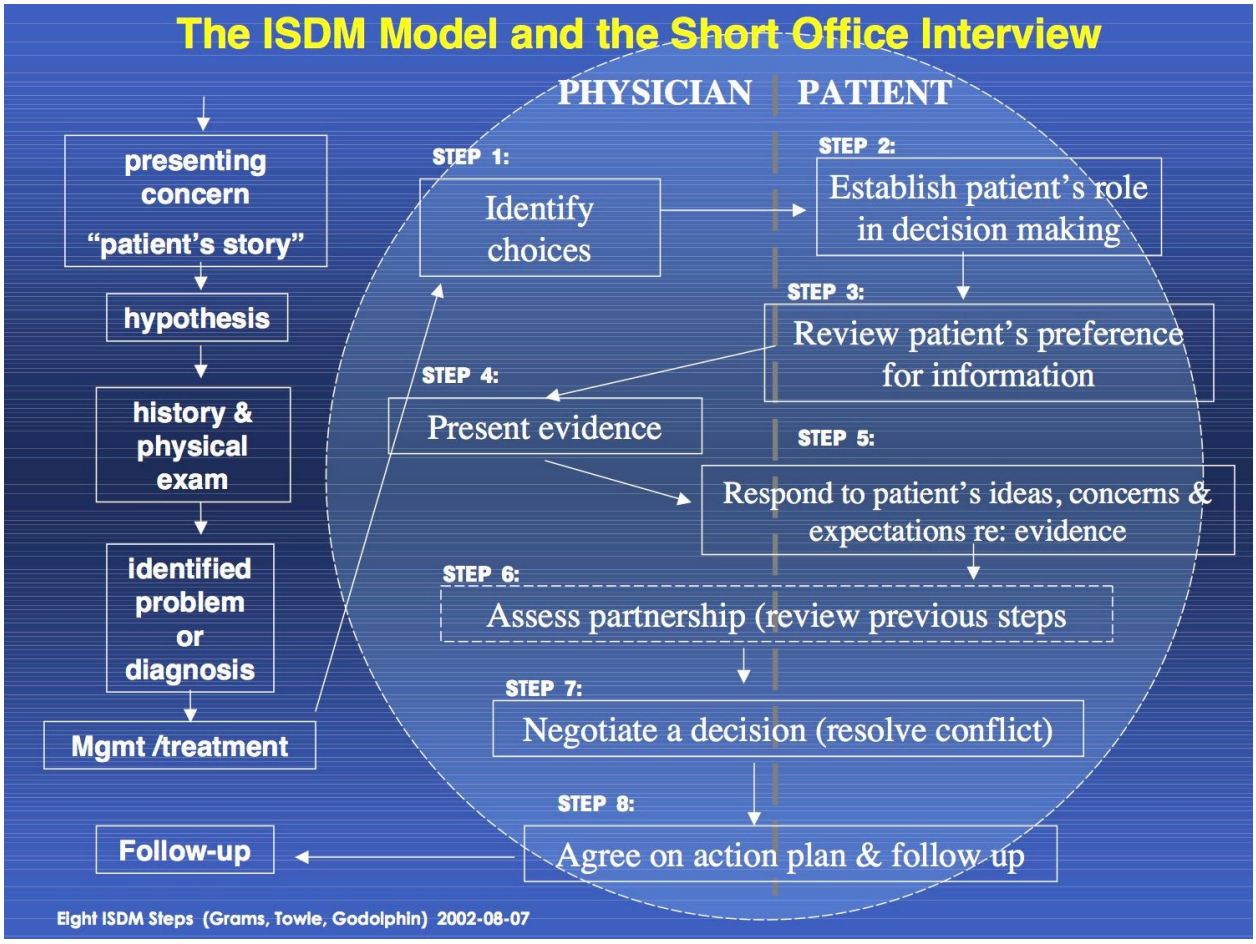
R **Recommend** treatment. Suggest a treatment plan that is developed with your client's involvement, including culturally appropriate aspects.

N **Negotiate** agreement.
The final treatment plan should be determined as mutually agreeable by both the health professional and client.

birth place lab

The Informed and Person-centered Decision Making (IPCDM) Model (10)

This model is a good example of the degree to which each person is responsible for contributing to the process. You can see this by looking at how much closer each step takes the physician and patient.



Both models convey and prioritize different aspects of shared decision making but ultimately achieve the same end.

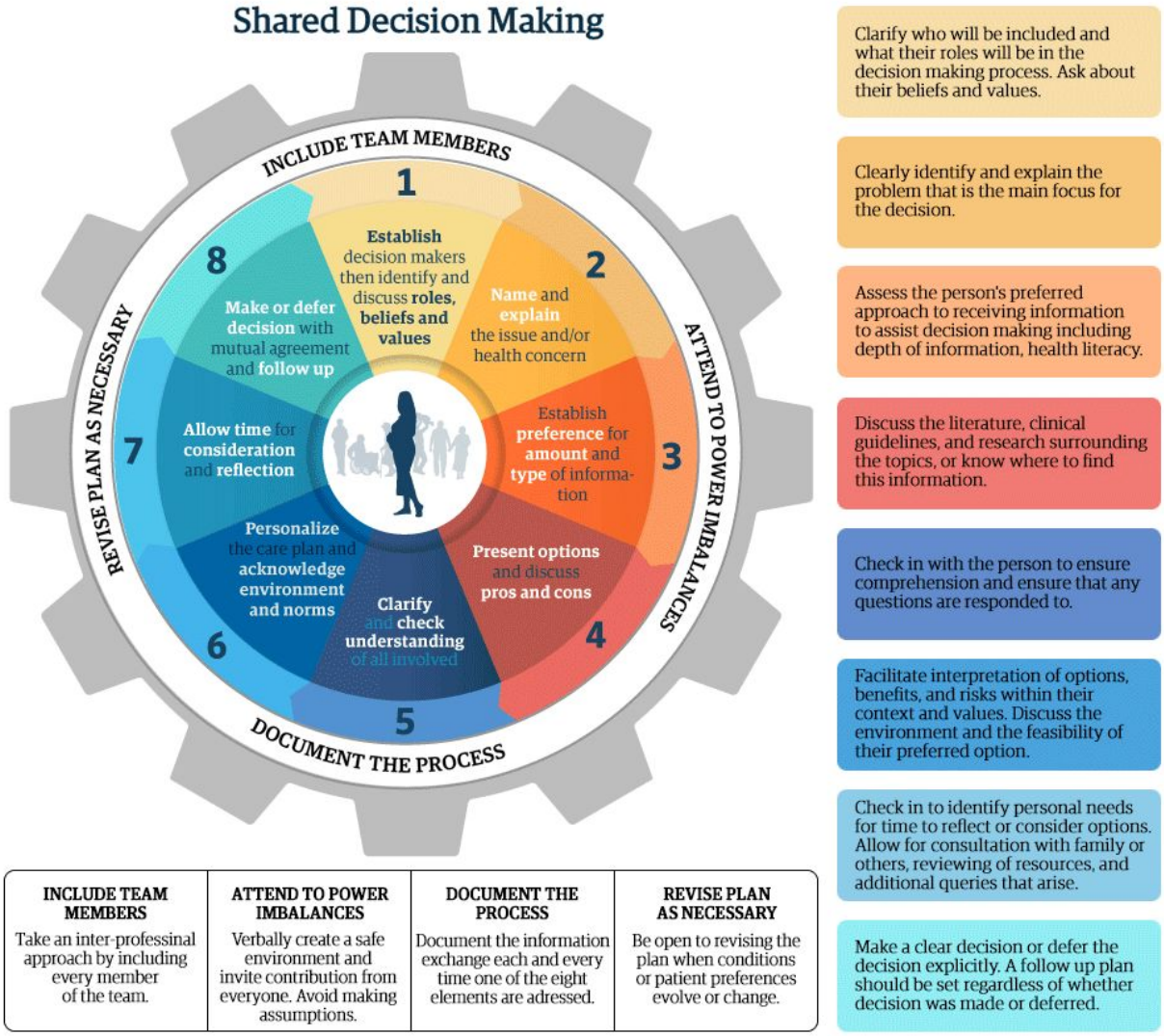
Since there is so much variety in models, to avoid confusion we have created our own graphic to highlight the key elements in the person-centered decision making process. This graphic includes the interprofessional team and the third person as part of the process. The focus is on the person: the provider individualizes the plan by eliciting values and beliefs from the person

receiving care and people they may identify as important to involve in decision making. Our graphic will be elaborated on at various points throughout the course. Take a really good look at it to become familiar with the content. A downloadable worksheet is also included with our graphic in the following unit.

Personal Reflection

Think of some examples in your field of work where there were more than two people involved in decision making for clinical care. What are the challenges this creates for people when they have different expectations about a similar process? How did the patient's experience inform the dialogue? How did beliefs and values of yourself and/or the patient inform the PCDM process?

The Birth Place Lab Decision Making Graphic



To explain the components of each step represented in the triangles on the wheel, please review this worksheet (printable pdf version).

Video: Person-Centered Decision Making Process

Watch this short video that models the use of many of the elements that support person-centered decision making. As you watch the video you will see prompts that identify the key elements. You may wish to stop and replay the labeled sections; this will allow you to learn, from a best practice model, about each technique within a real conversation with parents. *Note: this video was designed and filmed in British Columbia, Canada. Some content related to delivery of care is specific to Canada, but the person-centered decision making content is clearly applicable to a US audience.*

https://youtu.be/sVPQi9Q82Eg

Knowledge Check:

Which of the the key elements of the person-centered decision making process did you see demonstrated in the video? FOUR of the following are correct.

- Use an interprofessional approach.
- Document the process and plan.
- Identify and discuss beliefs and values.
- Acknowledge the impact of power imbalances.
- Name and explain the issue or health concern.
- Establish preference for type and amount of information.
- Present options.
- Discuss pros and cons using evidence-based information.
- Clarify and check the person's understanding.
- Determine who and how they will be involved in decision making.
- Make or defer decision with mutual agreement.
- Acknowledge any environmental factors.
- Allow time for consideration and reflection.
- Personalize the care plan.

Culturally Responsive Care

The United States is an increasingly diverse country and this affects people's preferences, whether they are the ones accessing or providing healthcare. Decision making processes are affected by innumerable factors that should be considered. These factors include, but are not limited to, an individual's experience of race, class, gender, age, assimilation, religion, ability, and cultural markers.

Culture impacts healthcare decision making in unique ways. Variety exists around:

- Attitudes and customs related to wellness, illness, birth, and death
- Communication styles
- Family roles and organization of "family" and community
- Food rules, taboos, and spirituality
- Customs related to modesty, privacy
- Adhering to ritual or tradition or choosing a "modern" lifestyle
- Concepts of risk and safety

An individual may specifically develop implicit biases based on their experience of race, class, gender, age, assimilation, religion, ability, and cultural markers. Implicit biases are unconscious prejudices that all persons hold across varying socio-political identities. These implicit biases can impact presentation of information in PCDM and interpretation of responses. All providers should be encouraged to explore their own implicit biases and consider the implication of those biases on patient care interactions. Project Implicit is one way to do this.

Forming Partnerships

Even within cultures, each person is unique, and their preferences may not predictably adhere to their culture of origin or the culture they have adopted. Approaching the clinician-patient relationship as a partnership can help you to avoid assumptions and to understand each person's unique values, beliefs, and preferences for their clinical care (11).

People bring three pre-existing perspectives to the clinical decision making process (10):

1. Information
2. Expectations
3. Preferences

Providers can find out more about people's perspectives by eliciting concerns, ideas, and expectations. This is the heart of person-centered care. Conversations to discover common ground should be intentional, explicit, and ongoing.

The key features of a healthy partnership are that everyone:

- Accepts mutual responsibilities
- Acknowledges that all partners have something to contribute and gain
- Pays attention to, and explicitly discusses, the relationship
- Allows the relationship to be dynamic and adapt to changing circumstances
- Understands that relationships and trust take time to develop, especially within the context of ways in which particular communities in the U.S. have been further marginalized through their contact with the U.S. healthcare system.

Personal Reflection

How do you encourage autonomy and facilitate dialogue around responsibility for your healthcare? What are points of access to resources that you have, that others might not? Can you track the privileges that have affirmed and supported or diminished the quality of your healthcare? Are there parts of your self-identity that have informed the quality of care you have received?

The Role of the “Third Person”

PCDM often includes individuals other than just the person and provider. Family members, friends, surrogates, religious/cultural leaders, or health advocates can also be involved in the decision making process. The effects of the role of a “third person” on clinical encounters have been studied and well documented (12, 13). They can:

- Facilitate or inhibit the development and maintenance of a trusting professional relationship
- Play multiple roles
- Affect the duration of the encounter and/or impact the content of the interaction
- Significantly change the basic clinical relationship, no matter how minor the involvement

Personal Reflection

Have you observed a clinician include a third person in the clinical care partnership? What was particularly effective when the third person was present? What was unhelpful? How could you reconcile differences between a clinician and a third person, or enlist them in the partnership?

Why do Providers Hesitate?

Let us explore some of the perceived barriers to person-centered decision making, and what the evidence says about these impediments (4, 6, 10, 11).

1) “It would take too much time to do all that”

Several studies have shown that providers trained in PCDM do not take significantly longer to conduct care. Learning to use a logical sequence can help save time; as a conversation is already taking place, person-centered decision making simply alters the nature of that conversation.

You will get lots of experience in this course applying skills that will help you to share decision making, which can be transferred easily to your clinical setting. For this course, we have chosen contexts where time is often of the essence. Person-centered decision making processes are typically taught in non-urgent scenarios such as an office visit. Often, issues brought up in a birthing context are more imminent or urgent. In this course, you will learn how to share decision making in both urgent and non-urgent scenarios.

2) “I already do that”

Evidence shows that providers and people do not always communicate well. People who are receiving clinical care rarely give direct feedback about communication problems. This may encourage providers to believe that there is no need to change or improve. In this course, you will practice giving and receiving feedback to a number of people to develop your verbal and non-verbal communication style. You will develop your self-awareness and learn the importance of verbal and non-verbal language when communicating. Person-centered decision making requires knowledge of key communication techniques, such as paraphrasing, summarizing, reflecting, open questioning, and sending messages. You will learn and practice these communication skills in this course.

3) “What about people who don’t want to be involved in their care?”

Sometimes people may feel uncomfortable with making a healthcare decision simply because they have never had the opportunity to do so before. It is a provider's responsibility to encourage autonomy in decision making, which includes sharing necessary information about treatment and listening to what is important to the patient/client. In this course, you will learn how to avoid making cultural and professional assumptions about people; these assumptions prohibit dialogue and strain relationships.

Healthcare providers also need to be able to facilitate dialogue about people's values, beliefs, and preferences because these often guide healthcare decision making. This is true for everyone who shares in the decision making process. You will learn how to identify and articulate the values, beliefs and preferences held by yourself and by your patient/client.

4) "There are too many barriers to interprofessional person-centered decision making"

Research shows that power differences attributed to gender, stereotypes, and social status affect collaboration. In this course, we will provide tools for interprofessional collaboration, team functioning, and conflict management.

Considering Risk and Benefit

To help people understand the risks and benefits of healthcare options in the context of their own lives, priorities, and values, you will have to learn how to present statistical concepts like "absolute vs relative risk" and consider ethical concepts like autonomy, beneficence, and non-maleficence. Click on the following link from the National Safety Council to learn how to place the absolute risk of dying within the context of familiar life activities.

NSC Risk visualization

Here is some advice from the published literature for providers who are engaged in risk conversations with people. If you want to explore this topic further you can read the articles in the *Learn More* section.

Summary of recommendations for communication about risk (14)

1. Use plain language to make written and verbal materials more understandable.
2. Present data using absolute risks.
3. Present information in pictographs if you are going to include graphs.
4. Present data using frequencies.
5. Use an incremental risk format to highlight how treatment changes risks from preexisting baseline levels.
6. Be aware that the order in which risks and benefits are presented can affect risk perceptions.
7. Consider using summary tables that include all of the risks and benefits for each treatment option.
8. Recognize that comparative risk information (eg, what the average person's risk is) is persuasive and not just informative.
9. Consider presenting only the information that is most critical to the patients' decision making, even at the expense of completeness.

10. Repeatedly draw patients' attention to the time interval over which a risk occurs.

Personal Reflection

What are some examples of priorities and concepts of risk and safety that might differ between clients/patients and providers? Have there been instances when your bias or opinion affected how you communicated risk?

Reflection: Informed Decision Making About Risk

In this activity you will be exploring how to best care for a person who is making choices that make you worried or uncomfortable. Below are several articles. They are all about concepts of risk in healthcare, but each have a different focus or perspective.

- What reactions do you have to the articles? Try to relate to the articles both as a healthcare provider and as a person receiving care.
- What is the take-home message for you? What do you want to convey to others?
- How might you apply what you have learned to a situation when someone in your care makes a choice that does not match with your own sense of risk and responsibility

Article 1 “Helping Patients Decide: Ten Steps to Better Risk Communication”

Article 2 “Reconceptualizing Risk”

Article 3 "Maternity Providers’ Perceptions of Women’s Autonomy and the Law”

Article 4 "Midwives' and Physicians' Perceptions of Risk and its Impact on Clinical Practice and Decision-Making in Labor"

The International Context for Care

U.S. healthcare mandates tend to be congruent with guidelines set by global health organizations--like the World Health Organization (WHO), the Federation of International Gynaecologists and Obstetricians, the National Institute for Clinical Excellence (NICE), and the United Nations Population Fund (UNFPA). All of these agencies have recently issued evidence-based statements and reviews that focus on patient experience as a key component of quality and safety in maternity care (15-18). In these evidence-based reports, respect, person-centered decision-making, choice of birth place, access to regulated providers, and interprofessional collaboration are all described as essential to addressing disparities in health outcomes for mothers and babies in both low and high resource countries. The Respectful Maternity Care (RMC) Charter, which is developed by the White Ribbon Alliance, "is based on a framework of human rights and is a response to the growing body of evidence documenting disrespect and abuse of childbearing women." (19, p. v)

Here are some messages from the global reports that are relevant to what you will learn in this course:

> "In recent years, a movement has been advancing to promote implementation of more respectful maternity care, emphasizing the importance of underlying professional ethics and psycho-socio-cultural aspects of health care delivery as essential elements of care. As early as the 1970s, in the United States and Canada, some recognition of the need for respectful care was made by doulas, midwives, women giving birth, ... doctors and nurses, and so a movement developed for the humanization of childbirth." (19, p. 1)

> "Increasing the proportion of women delivering in a health facility is challenging, as it requires comprehensive efforts to overcome sociocultural, economic, geographical, and infrastructural obstacles to reaching facility-based care. Furthermore, it requires efforts to improve both the coverage and quality of care provided to women and health facilities, including women's rights to dignified and respectful care." (6, p. 2)

".... several recent studies and reports clearly indicate that many women globally experience poor treatment during childbirth, including abusive, neglectful, or disrespectful care. Every woman has the right to dignified, respectful sexual and reproductive health care, including during childbirth, as highlighted by the Universal Rights of Childbearing Women charter. Therefore, mistreatment during childbirth can represent a violation of women's fundamental human rights and can serve as a powerful disincentive for women to seek care in facilities for their subsequent deliveries. In September 2014, a World Health Organization statement called for greater research, action, advocacy and dialogue on this important public health issue, in order to ensure safe, timely, respectful care during childbirth for all women." (6, p. 2)

A Snapshot of the United States Context

Most people in United States receive physician-led, hospital based care. Obstetric care in hospitals are largely based on guidelines established by the American College of Obstetricians and Gynecologists (ACOG), but practice is also guided by clinical guidelines and research from the National Association of Certified Professional Midwives (NACPM), National Association of Registered Midwives (NARM), the American College of Nurse-Midwives (ACNM), and the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). Community-based birth, in home and birth center settings, make up 1.5% of all births in the United States (45). This percentage is still overall small, but has been trending upward since 2004 (46).

Until the early 1800s, the United States had a rich history of midwives living and working within communities and attending home births. Beginning in the 1830s-1840s there was a move to delegitimize home-based midwifery in favor of physician-attended birth in hospitals. By the 1950s, midwives began to professionalize and re-enter society’s healthcare consciousness.

Midwives can be nationally certified and are variably licensed by states. Current midwifery credentials in the United States include certified professional midwives (CPM, licensed in 32 states), certified nurse-midwives (CNM, licensed in 50 states) and certified midwives (CM, licensed in 5 states). CPMs are certified nationally by the North American Registry of Midwives (NARM). CNMs and CMs are certified nationally by the American Midwifery Certification Board (AMCB). Institutions that train CPMs, CNMs and CMs each have national accreditation from an agency approved by the US Department of Education.

CPMs primarily attend birth in birth centers and homes. CNMs/CMs also attend birth in birth centers and homes, but primarily attend birth in hospitals. CNMs/CMs scope of practice additionally includes prescribing and a breadth of primary, sexual and reproductive healthcare. “Direct-entry midwifery” refers to midwives that are not primarily prepared as nurses. “Lay midwifery” typically refers to midwives without formal training and is often used pejoratively.

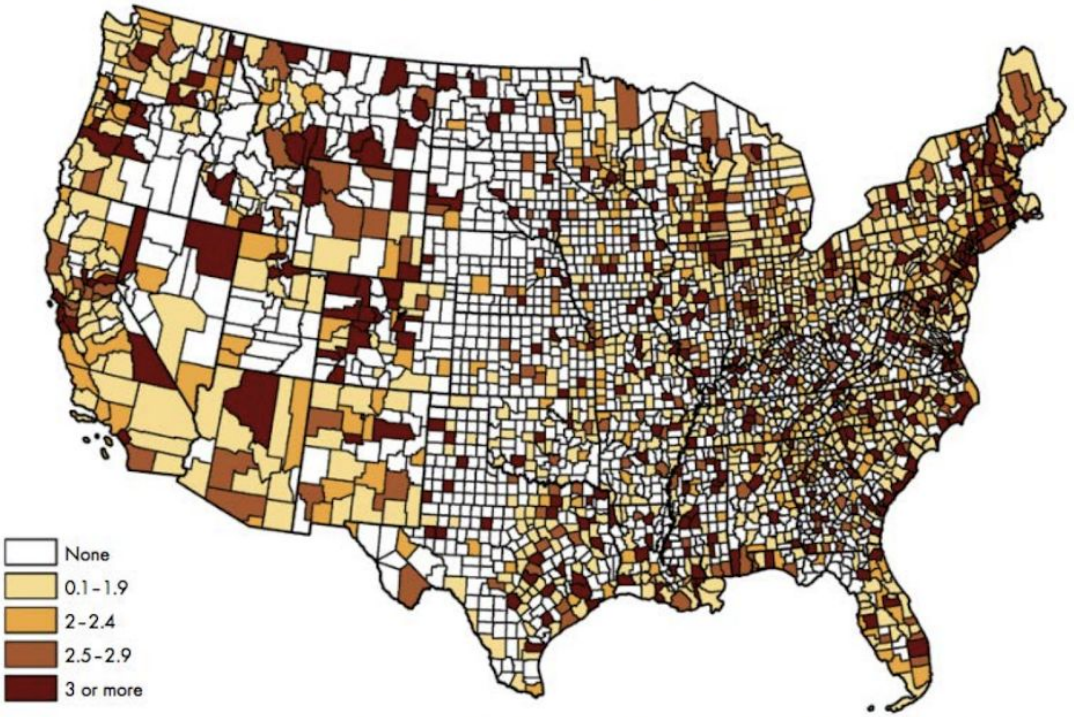
Certified nurse-midwives (CNM) now attend 8.3% of total births in the US and 12.1% of all vaginal deliveries. The United States currently faces a shortage of obstetric care providers,

especially in rural areas where more than 10 million women (8.2% of American women) live. About 49% of the United States' 3,143 counties do not have a single OB/GYN.

Recent research from the Birth Place Lab (44) at the University of British Columbia reveals that states with greater access to midwifery care and better integration of midwives into the health care system also have better obstetric outcomes, such as decreased cesarean birth rates, preterm birth and low birthweight, and increased rates of breastfeeding and vaginal birth after cesarean.

United States

Obstetrician–gynecologists per 10,000 women in the United States, 2010



ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Sources: American Congress of Obstetricians and Gynecologists. Membership information. Washington, DC: American Congress of Obstetricians and Gynecologists; 2010 *and* American Fact Finder. American FactFinder. Washington, DC: US Census Bureau; 2012. Available at: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Retrieved August 2, 2012.
Produced by: American Congress of Obstetricians and Gynecologists' Workforce Studies and Planning Group

Access to Maternity Care Providers

9.5 million Americans live in rural counties with no ob-gyn (49% of counties)

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Interprofessional tensions between physicians and midwives in the US have persisted over decades. In the face of the maternity workforce shortage, it has become imperative to focus on improving collaborative care. Three key issues are at the heart of the tension: the safety of home birth, the education standards for midwifery practice, and autonomous practice of midwifery. In 2006, ACOG endorsed AMCB education standards. In 2011, ACOG published a joint statement with the American College of Nurse-Midwives (ACNM) in support of collaborative care and autonomy of CNMs/CMs. In 2015, ACOG published a position statement in support of education and training standards of the International Confederation of Midwives, which includes many CPMs. These policy changes have been successful at reshaping relationships between physicians and midwives, but home birth policies have essentially remained at a stalemate.

A compounding contextual issue is the sobering maternal mortality rate in the US. Although the US spends more per capita on healthcare than other countries of similar income levels, the US maternal mortality rate has increased significantly in the past 25 years. This elevation in mortality rate is not uniform, however. Black women are three to four times more likely than their White, Asian, or Latinx pregnant peers to experience a pregnancy-related death (40). According to the CDC pregnancy mortality surveillance system that evaluated 100,000 live births between 2011-2014, the population of Black women experienced 40.4 deaths, compared to 12.4 deaths among white women and 17.8 deaths among women of other races (41). The structural violence of racism correlates with poorer outcomes, as the pathophysiological causes of maternal mortality differ across racial and ethnic identities. For example, US-born Latinx women continue to experience a high mortality rate due to conventional causes of pregnancy-related death that are in decline for US-born non-Latinx, such as hypertensive disorders of pregnancy, hemorrhage, and venous thromboembolism (42). In addition to higher mortality rates, maternal morbidity in people of color is significantly elevated. A study of American Indian and Alaska Native women - an under-researched population that primarily receives care at Indian Health Service (IHS) medical centers - found four times the rate of postpartum hemorrhage, three times the rate of gestational diabetes at delivery, and nearly twice the rate of pregnancy-related hypertension compared to women in the general US population (43).

Reflection: Context of Care

Instructions

In this activity you will be considering your ideas for innovative solutions regarding the health resource challenges in the US. You will have the opportunity to examine readings that explore the evidence on the topic from different perspectives. The purpose of this assignment is to inform your reflection so that you can effectively engage in a robust dialogue with your peers.

1. Review the documents (see links below) and consider the following questions:

- What impressions do you have about the distribution of options for birth setting across the US? How does this impact people receiving and giving care?
- How might the changing demographic of maternity providers affect access to maternity care in the next decade?
- How might birth setting and/or the availability of human health resources affect cost-effectiveness of care?

2. In light of the readings, identify potential solutions to the challenges that families may experience when seeking access to maternity care across the US.

Click on the links below to see reports on these topics. If you desire more in-depth information on the topic, you can explore the source documents that are cited.

- Levels of Maternal Care, and who is caring for pregnant families in the US
- Maternal Mortality: new strategies for measurement and prevention, and improving maternity care in the US
- NIHCM Webinar: Maternal Health in Crisis: Ensuring Nationwide Access to Maternity Care Providers
- American College of Nurse-Midwives: Full Practice Authority
- ACOG Committee Opinion No. 586: Health disparities in rural women

Additional Resources:

- Obstetric outcomes in rural US
- Rural America's disappearing maternity care
- Midwives: The answer to the US maternity care provider shortage

Why Home Birth?

Reflecting on choice of place of birth, write 3-5 reasons why an individual might choose to give birth at home rather than in the hospital setting. You can also review the findings of research on choice of birth place in the resources section.

Place of Birth: People, Preferences, and Preparation

The decision about the best place to give birth is a personal and complex process that involves consideration of physical well-being as well as cultural, social, emotional, and spiritual values and preferences. In both hospital and home settings, birthing people describe their needs for autonomy, safety and choice of options for care. When they are involved in decision making, birthing people report that they feel that they and their newborn will be safe in either setting (2, 9, 13, 25). When a birthing person is able to experience and respond to her body's cues in a private environment, with support from family, and the continuous presence of a known care provider, progress in labor and birth is facilitated (8). For many, an undisturbed birth space and a sense of control over their environment can reduce their perception of pain and suffering, and can contribute to a positive and empowering birth experience (12).

Over the course of pregnancy and labor, maternity care in the US may take place at home, in a birth center, or in a hospital. However, the birth place choices that are available are influenced by the type of services, equipment, and personnel that are available in the local community (35). Moreover, the OB/GYN workforce shortage, state-specific barriers and out-of-hospital birth has created maternity care deserts within the U.S. At the same time, interest in planned home birth and postpartum home care is growing, increasing the demand for midwives.

When care providers understand the nature of care and personnel in all available settings, they are able to facilitate PCDM around birth site. Additionally, when transfer from one setting to another is necessary, access to a well-informed, receptive, respectful healthcare team can contribute to positive outcomes for the childbearing family (26).

Video: Factors Influencing Choice of Birth Place

Many factors can influence the choice of birth place; and the evolution of the condition of mother, baby, or environment may lead to a change of plan. Watch the video below to learn more about these factors. *Note: this video was designed and filmed in British Columbia, Canada. Some content related to delivery of care is specific to Canada, but the content is still applicable to a US audience.*

https://youtu.be/YbqNqPTZx5c

Knowledge Check:

What element of shared decision making was demonstrated in this dialogue?

- Valuing the birth parent's concerns most since they are the primary decision maker
- Providing information to guide decision making
- Reassuring the family that the risk is small
- Clarifying that decisions surrounding hospital transfer are made based on best professional judgment
- Presenting the advantages of home birth in a clear manner

Reflection: What do you think?

Reflect:

1. On a piece of paper or electronic notepad, make a list of 5 words that describe your first thoughts when you hear "home birth".
2. List and describe 2 differences between a planned home birth and an unplanned home birth. Base your comments on your own life experience and education, not from online resources.

What is a Planned Home Birth?

Planned home birth is when, after the onset of labor, an essentially healthy pregnant person at term intends to deliver at home, and is attended by qualified maternity care professionals. Standard labor and delivery equipment and medications are available in the home, and access to hospitalization and/or specialist consultation, if necessary, are included in the plan.

Evidence-Based Selection of Birth Setting

Researchers have compared the health and well-being of mothers and babies across birth settings for many years. However, until recently, studies did not clearly differentiate outcomes from births at home or birth centers with skilled attendants from outcomes of unplanned or unattended home births. Since 2009, several large population-based and matched cohort studies have established that for people without risk factors there are significant reductions in use of obstetric interventions when labor and birth occurs in homes, birth centers, and midwife-led hospital units, with no significant differences in adverse outcomes (1, 10, 11, 20, 21, 23). While there are some differences in neonatal outcomes across settings among women in the first pregnancy, in high resource countries the absolute risk of adverse medical outcomes are extremely small in all settings (24). As a result, Britain's **National Institute for Health and Care Excellence (NICE)** recommends that providers,

> "Explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth.
>
> Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.

> Advise low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby." (17)

Personalizing the Decision

The concept of risk is always interpreted from a personal perspective and may not always align with the provider's definition of risk (33, 34). For example, the distance to hospital, access to skilled personnel or specialized equipment, access to special foods or extended family support, and/or ability to engage in rituals, undisturbed, are all factors that may influence a woman's immediate feelings of security and safety. Even when the place of birth is planned, people will respond differently to the labor and birth environment depending on individual physical and life circumstances. Someone planning to deliver in the hospital may change their mind during labor and choose to give birth at home with a skilled attendant. Other persons may plan to give birth in a hospital but ultimately move to a different setting because of need for specialized medical care or environmental factors such as changes in weather or travel conditions.

What do Clients and Providers Say?

What do people say about their experience of birth?

> *"If you have to go to a hospital, having someone there who you know is on your side, who shares your values, who you've chosen to be on your team, that you've spent time with leading up to the birth and then who would continue to be with you afterwards, is just so, so worth whatever you have to do to pay for it [laughing]…Having familiar faces there, people you trust, whose opinion you trust, I think that is the key to having a positive birth experience...."*

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"I was immediately struck by how clinical and white it [hospital] was. It just didn't have any warmth to it at all. The lights were bright and the room felt bare and unhomely."

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"Anytime I had to make a decision about anything, I always asked them [hospital staff] if I could have some time with my team to discuss it, and they left us alone and gave us space, as much as we needed. I was able to talk things over with my partner and make decisions…I found that really, really excellent."

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"That was why the break down happened because I built this relationship with one person for my entire pregnancy and then I just meet this guy at the end of the day who is taking care of my natal birth. Right, so, I don't know. It's just frustrating."

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"What an exceptional experience that was, a privileged, professional but also personal [experience]… I had the best care, the absolute best care…What I saw was how well the home care in labor worked, the midwives…the ambulance, the hospital, and the after-care… they all worked so professionally amongst each other to give me and my baby the best care."
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What Do Evidence-Based Guidelines Say?

> All healthcare professionals should ensure that in all birth settings there is a culture of respect for each person as an individual undergoing a significant and emotionally intense life experience, so that the birthing person is in control, is listened to and is cared for with compassion, and that appropriate informed consent is sought. (17)

> Senior staff should demonstrate, through their own words and behavior, appropriate ways of relating to and talking about birthing people and their birth companion(s), and of talking about birth and the choices to be made when giving birth. (17)

Personal Reflection

What are some examples of priorities and concepts of risk and safety with respect to birth place that might differ between patients/clients and providers?

Public Health Implications

It is well established that the birth environment can affect the caregiver's use of technology and influence the physiology of normal labor and birth. Researchers have demonstrated reduced costs to the healthcare system, with no increase in complications, when healthy people plan to birth in low technology settings with skilled providers, even if some of them actually deliver in the hospital after transfer (36, 37). Hence, public health researchers and human health resource planners globally and state-wide recommend that maternity care should occur in the lowest resource setting where the person feels safe and comfortable, and can access skilled attendants as appropriate to their individual clinical situation for each labor and birth (15, 17).

Personal Reflection

What items (equipment, personnel, care processes, or resource utilization) might drive the differences in costs between settings?

Assessing Your Understanding

Now that you have completed the units in Module 1: Person-Centered Care, complete the following questions to assess your understanding of the application of tools, techniques, and strategies.

1. Please identify 3 actions that apply throughout a person-centered decision making conversation. (3 items are correct)

- Document the process and plan.
- Identify and discuss community standards.
- Acknowledge the impact of power imbalances.
- Explain adverse outcomes associated with the health concern.
- Establish preference for type and amount of information.
- Make or defer decision with mutual agreement.
- Allow time for consideration and reflection.

2. According to research on people's preferences and experiences, the most common reasons for choosing planned home birth in high resource countries include: (4 items are correct)

- Increased sense of safety
- Reduced cost
- Avoid interventions
- No child care
- Desire for water birth
- No maternity provider in community
- Privacy
- Latex or olfactory allergies
- Ability to control decisions
- No transportation

3. Person-centered decision making has mutual benefits to providers and clients. Person-centered decision making:

- Increases uptake and access to diagnostic tests
- Facilitates health care referrals
- Expands the opportunity for agreement between people
- Strengthens dialogue and avoids conflict

4. People bring 3 pre-existing perspectives to the clinical decision making process. These 3 things are:

- Expectations
- Concerns
- Feelings
- Preferences
- Ideas
- Information
- Attitudes
- Past experiences

5. What effect does the "third person" have on clinical care?

- They facilitate dialogue and develop a relationship with the providers.
- They inhibit disclosure by clients and affect the clinical care of the client.
- They represent the client and interpret provider information.
- They impact development of professional trust and participate in decision making.

6. When sharing decision making, how can you keep the focus on the person?

- Individualize the plan by eliciting a person's values and beliefs.
- Discuss the person's social and medical history with the care team before making a plan.
- Use a facilitated discussion protocol to bring the person into the planning process.
- Ask the person what they want and how you can help them.

7. Most people in the United States receive physician-led, hospital based care and have limited access to other options for settings or providers, especially in rural and remote locations.

- True
- False

8. Which statement is TRUE regarding Level One, Level Two, and Level Three hospitals?

- Level One hospitals do not have C-section capability.
- Level Two hospitals have 24/7 on-call specialty consultation available in their community.
- Level Three hospitals do not have capacity for twin births under 28-week gestations.
- Level One hospitals have capacity for deliveries at 36-week gestation and beyond.
-

9. US midwives are required by regulation to offer and attend both home and hospital births.

- True
- False

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Module Evaluation

[Embedded survey.]