ISSUE BRIEF

Promoting Shared Decision-making in Maternal Health Care

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The utilization of shared decision-making practice in maternal health care has the potential to improve the overall pregnancy, birth, and postpartum experience. This issue of the *NCMJ* highlights various programs and initiatives aimed at improving maternal health outcomes, including efforts to build a more diverse perinatal workforce.

Introduction

The experience of birth profoundly affects a woman and her family. The memory of birth can be vivid and detailed for years after it occurs. Many birthing persons[a] find joy in recounting their birth story; the experience can be enhanced or diminished by the place of birth, the provider, and whether the birthing person feels heard and included in decision-making about their care. Some birthing people report feeling transformed and empowered after birth because they felt supported, listened to, and respected; others report an opposite experience. This paper will describe how the utilization of patient engagement strategies, specifically shared decision-making (SDM), can improve the experiences of birthing people during pregnancy and birth, as well as maternal health outcomes. The importance of SDM and the active engagement of birthing people in decisions about their own care has been identified as an integral component to the provision of high-quality maternity care [1]. The perinatal workforce in the United States is underresourced and lacks racial and ethnic diversity [2]. Some experts suggest that disparities in maternal health outcomes can be reduced by increasing workforce diversity and having more culturally congruent maternity care [2]. Culturally congruent providers have been shown to improve patient experience, increase patient satisfaction, and improve access to care for historically marginalized patients [2].

During the COVID-19 pandemic, health care providers innovated to meet the needs of pregnant and postpartum persons across the state. This issue of the *North Carolina Medical Journal* highlights various programs and initiatives aimed at improving maternal health outcomes; strategies for enhancing the birthing person's experience and satisfaction with the care received during the perinatal period; efforts to build a diverse perinatal workforce; and several innovative maternal health programs that adapted to meet the needs of pregnant and postpartum persons during COVID-19.

Improving Maternal Health Outcomes Using Shared Decision-making

In the United States, approximately 80% of preventable adverse medical events are caused by failures of communication and teamwork [3]. Patient-practitioner communication is often cited as a major root cause of obstetric sentinel events and other adverse outcomes. Globally, the right to information, informed consent, and respect for the birthing persons' choices and preferences during childbirth are considered universal human rights. Abiding by the principles of respectful maternity care, including improved communication among care teams and SDM with the birthing person, is an essential component of quality of care [3].

SDM is a process of communication in which providers and patients work together to make optimal health care decisions that align with what matters most to patients. In 2018, the National Quality Forum published a playbook entitled *Shared Decision-making in Health Care*, which outlines guidance for providers to implement and strengthen SDM [4]. In the perinatal period, SDM has the potential to improve the overall pregnancy, birth, and postpartum experience and enhance engagement between providers and pregnant or postpartum persons. Despite the proven effectiveness of SDM, the adoption of the practice is limited among health care providers.

Birth is the most frequent cause of hospitalization for women [5]. Interaction with the health care system during pregnancy and birth is different from any other interaction within the health care system. Pregnancy and birth are normal physiologic processes, not illnesses, that bring about different hopes and aspirations for each pregnant person.

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a "Birthing person/people; pregnant person" refers to someone who gives birth, regardless of their gender. The author embraces this more inclusive construction while not abandoning the traditional use of the term "mother."

Unfortunately, approximately 700 women in the United States die every year during the perinatal period [6]. The United States continues to be an outlier among industrialized nations, with a maternal mortality rate significantly higher than other high-income countries; the US maternal mortality rate is almost three times higher than that of France, the country with the next highest rate [7]. To reduce pregnancy-related deaths, SDM, standardized protocols, and other strategies must be used to provide equitable maternity care, particularly to women of color [8]. SDM holds promise for improving health equity by better engaging patients in health care [9]. The work of Baker and Faustin, cofounders of the Health Equity and Racism Lab (H.E.R. Lab), is to intentionally and systematically center the analysis of "race" and racism as the main contributors to health inequities [10]. In their article in this issue, the authors share about mentored student-directed and -led projects committed to addressing racism and health inequities in maternal health through their research, teaching, and community engagement [10].

SDM and Reproductive Health

Given the history of eugenics and reproductive coercion in the United States, supporting patients through the contraceptive decision-making process is especially vital. Shared contraceptive decision-making occurs when patients provide input on their values, desires, and preferences and clinicians share medical knowledge and evidence-based information without judgement. This approach is considered the most ethically sound form of counseling, as it maximizes patient autonomy. Shared decision-making also has clinical benefits, including increased patient satisfaction [11].

In this issue, Wise and Urrutia acknowledge that while use of long-acting reversible contraception (LARC) is growing in North Carolina, reducing barriers to accessing LARC will likely result in larger uptake and reductions in short interpregnancy intervals [12]. Barriers to LARC use include cost, access to immediate postpartum and same-day LARC placement, and provider education. The American College of Obstetricians and Gynecologists (ACOG) recognizes SDM as a strategy to be used by providers to deliver the most up-to-date information on LARC methods. ACOG has made available LARC Counseling Scenario videos to demonstrate how to use a decision aid during contraceptive counseling to facilitate shared decision-making [13].

SDM and Substance Use Disorders in Pregnancy

In a US *Survey of SDM Use for Treating Pregnant Women Presenting with Opioid Use Disorder*, ACOG concluded that providers were more likely to use SDM if they had training in substance use disorder (SUD) treatment and felt prepared to care for pregnant persons with opioid use disorder (OUD) [14]. The SUD-related articles in this issue by Patterson, Swartz, and coauthors highlight that the use of opioids during pregnancy can lead to adverse maternal and infant outcomes, including maternal death, and that some maternal health providers still have conscious and unconscious biases against pregnant SUD patients, which affects their ability to provide care or leads them to make erroneous judgments about the patient [15, 16]. In working with pregnant or postpartum persons with a substance use disorder, the SDM model can be empowering and less threatening. Patterson identifies motivational interviewing as an effective strategy for drawing out patients' priorities, values, and preferences for change and support.

SDM and Racially Concordant Care

Racially concordant care places focus on the patient care experience. In a 2020 article in the *Journal of General Internal Medicine*, authors describe a randomized experiment in which Black patients viewed the racially concordant doctor in a scripted video vignette more positively, and were more receptive to the same recommendation, communicated in the same way, with a Black rather than White physician [17]. The authors also found that patient-provider race concordance is associated with higher ratings of physicians and better perceived communication, particularly among Black patients [17].

In North Carolina and across the United States, pregnant people experience challenges in finding a provider who shares their race. A perinatal workforce that is well-trained, appropriately distributed, and racially and ethnically diverse is the ideal combination for providing quality maternity care. Coulson and Galvin note in this issue that there is a lack of racial and ethnic representation within the perinatal workforce across the United States, with substantial underrepresentation by providers other than White or Asian/Pacific Islander [18]. Prior to COVID-19, efforts were already established to recruit, train, and retain health care providers in North Carolina. The COVID-19 pandemic significantly stressed an already fragile system, particularly in rural areas. In an interview, Duke OB/GYN Residency Director Dr. Beverly Gray shares that the stresses of the COVID-19 pandemic are changing the landscape of medical education [19]. Prospective doctors now are advocating for family-friendly workplaces to improve workforce well-being, according to Gray. Coulson and Galvin highlight several strategies for building a more diverse perinatal workforce, such as place-based education, which in North Carolina includes a growing number of medical schools and residency programs, including programs with an emphasis on rural training. This strategy is one of many shown to increase a perinatal workforce that can provide racially concordant care.

In the *White House Blueprint for Addressing the Maternal Health Crisis* report published in June 2022, building a doula workforce was identified as a critical piece in the effort to improve maternal health [2]. The perinatal doula training program for Black women by Black women described in the article in this issue by Standard and coauthors is an example of expanding the doula workforce while providing racially concordant care [20]. The authors state that the

trained doulas are the liaisons to the Black community, who will increase trust, build relationships, and increase open communication between patients and providers for shared decision-making. In a 2021 qualitative study by Kathawa and coauthors, the findings reinforced the hypothesis that doulas of color are uniquely well suited to support women of color and that tensions surrounding race discordance between women and providers can be alleviated by the presence of a doula from a similar background to the birthing person [21]. The perinatal doula training program described in the Standard article recognized the need to enhance traditional birth doula training with content that would create more culturally appropriate and concordant doula training. One barrier to building a diverse doula workforce is the cost of training and certification. In this issue, Elizabeth Star-Winer of the Winer Family Foundation discusses her organization's work to leverage funds to support doula projects aimed at training Black women as community doulas [22].

Another workforce development program highlighted in this issue is the Pathway 2 Human Lactation Program at North Carolina Agricultural and Technical State University (NC A&T). The goal of this program is to increase diverse representation in the lactation workforce, increasing the number of culturally aware International Board Certified Lactation Consultants (IBCLCs) [23]. The NC A&T lactation program recognizes the importance of effective communication in health care by providing five hours of didactic coursework in communication. The purpose of these courses is to provide students with a firm foundation in culturally sound care, based in part on a community-based breastfeeding peer support program in Tennessee, which found that systematic barriers and disadvantages faced by Black women can be reduced through multilevel protective factor interventions and programs [24].

Innovation During COVID-19

The COVID-19 pandemic disrupted the provision of care in the maternal health care system. During the pandemic, systems had to prioritize services offered. Due to national and state-level lockdowns, pregnant and postpartum persons were hesitant to leave their homes, which affected their participation in necessary prenatal and postnatal appointments. Prior to COVID-19, health disparities and poor maternal health outcomes were disproportionately high in our state. There was concern among public health leaders that the pandemic would widen these disparities and further negatively impact maternal health outcomes. Several articles in this issue highlight innovative programs that were implemented during the pandemic to maintain continuity of maternal health services and the identification of post-birth warning signs to reduce maternal morbidity and mortality.

In July 2020, ECU expanded NC-STeP, a statewide telepsychiatry program, to bring multidisciplinary care to three community-based primary care obstetric clinics in Carteret, Duplin, and Chowan counties. The MOTHeRS (Maternal Outreach through Telehealth for Rural Sites) Project brought together the primary obstetrician in the three rural counties with providers in multiple other aspects of patient care, including a maternal fetal medicine specialist (MFM), a psychiatrist, a diabetes educator, a behavioral health manager, and a nurse navigator [25]. The MOTHeRS project addressed several factors impacting pregnant and postpartum women during this time, from perinatal mental health to food insecurity.

In May 2020, BirthCompass (formerly COVIDMoms Helpline) launched a free text helpline staffed with knowledgeable experts and perinatal educators, available by SMS text or Facebook messenger. The helpline provided a resource for pregnant persons and new families to freely ask questions about pregnancy or postpartum care during COVID-19 and get rapid responses from qualified perinatal educators. BirthCompass recognized through the questions being asked that pregnant persons needed more information about birth and/or lactation than the text messages provided [26]. During the pandemic, in-person prenatal education classes, such as childbirth education and lactation classes, were no longer available, which created further social isolation for pregnant persons. Therefore, BirthCompass expanded its services to include virtual education sessions.

The final innovative program highlighted in this issue was designed to identify complications that present during the postpartum period that contribute maternal morbidity and mortality. Persons who gave birth at ECU Health facilities between August and November 2021 were given an "I Gave Birth" bracelet and provided with post-birth warning signs education. Hospital staff, including emergency medicine workers, were also educated on the "I Gave Birth" initiative and post-birth warning signs. A review of data from the period of implementation found that readmissions decreased and those seeking emergency care were seen within minutes [27]. Both findings were thought to have a direct correlation with the education and interventions provided by the "I Gave Birth" initiative. NCMJ

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