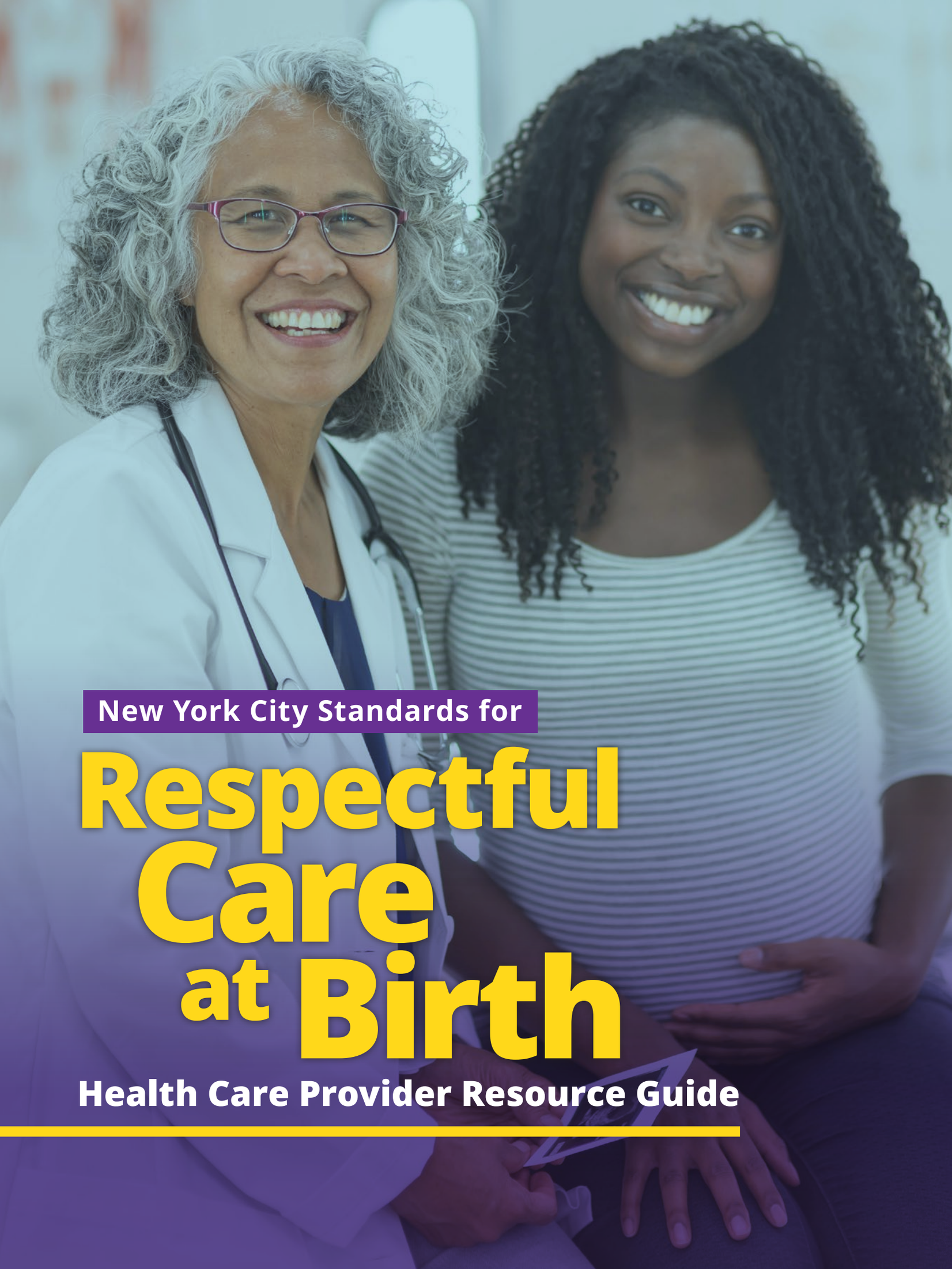

New York City Standards for

Respectful Care at Birth

Health Care Provider Resource Guide

NEW YORK CITY STANDARDS FOR

RESPECTFUL CARE at BIRTH

You have a human right to respectful, safe and quality care during your birthing experience.

EDUCATION

You deserve to ask for and receive simple information that you can easily understand about your health care, health care provider and birthing experience options.

DECISION-MAKING

You deserve to decide what happens with your body and to make decisions for your baby.

SUPPORT

You deserve to receive support during pregnancy, labor and childbirth, as well as after childbirth.

INFORMED CONSENT

You deserve to know and make your own decisions about all of your medical procedures. This is called “informed consent” and is a legal right.

QUALITY OF CARE

You deserve the highest-quality health care.

DIGNITY AND NONDISCRIMINATION

You deserve to be treated with dignity and respect during pregnancy, labor and childbirth, as well as after childbirth – no matter what.

New York City Standards for

Respectful Care at Birth

Health Care Provider Resource Guide

Contents

Acknowledgments

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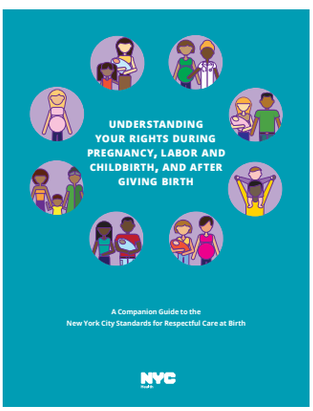
I. Introduction

In 2015, the New York City Department of Health and Mental Hygiene (NYC Health Department) and a group of community members convened the first meeting of what would become the **Sexual and Reproductive Justice Community Engagement Group** (SRJ CEG), comprised of more than 50 leaders from communities impacted by racial and ethnic inequities in sexual and reproductive health.[1,2] Until 2019, the SRJ CEG met monthly to plan and implement activities designed to ensure all New Yorkers can safely express their sexuality, gender identity, and reproductive choices with dignity.

The NYC Health Department is committed to advancing health equity through community engagement: "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest or similar situations to address issues affecting the well-being of those people." [3,4]

After gaining input from community members, the SRJ CEG and the NYC Health Department developed the **New York City Standards for Respectful Care at Birth** (NYC Standards) to inform and educate people about their rights during pregnancy, during labor and childbirth, and after giving birth. Released on December 10, 2018 (Human Rights Day),[5,6] the NYC Standards serve as a response to inequities in maternal health outcomes in NYC, where Black women are nine times more likely to die from pregnancy-related causes than non-Latina* White women, and three times more likely to experience severe maternal morbidity (SMM).[7,8] Compared with non-Latina White women, Latina women are more likely to experience SMM, and Latina and Asian American and Pacific Islander (AAPI) women are at higher risk of pregnancy-associated mortality.



The following year, the SRJ CEG and the NYC Health Department released a community **Companion Guide** to support pregnant, birthing, and parenting people in knowing, understanding, and exercising the rights outlined in the NYC Standards.

This Health Care Resource Guide is designed to support individual health care workers and practice sites to implement the NYC Standards as part of the broader movement to eliminate racial and ethnic inequities in birth health outcomes in NYC.

*This guide uses the terms Latino and Latina, but providers may also hear and/or use gender-inclusive terms such as Latinx or Latine. Providers should use the term each client prefers.

The Legacy of Racism in Sexual and Reproductive Health Care

The legacy of American chattel slavery* has forever marked every segment of society in the United States (U.S.) and perhaps none more clearly than medicine.[9,10,11] The medical community has exalted Dr. James Marion Sims as the "father of American gynecology" for his development of the vaginal speculum and a surgical technique to repair vesicovaginal fistula.[12] These innovations resulted, however, from years of forced, painful, and unanesthetized experimentation on Black women — Lucy, Anarcha, and Betsey, as well as seven others, unnamed — who were enslaved by European Americans.[13] A statue of Sims was recently removed from Central Park, across from the New York Academy of Medicine.[14,15] Harlem community members and Racial Justice activists had long called for the statue's removal, arguing that it was an egregious reminder of past and present racism that communities of color are forced to endure within medicine.[16,17,18]

Additional injustices perpetrated against women of color woven into the fabric of obstetrics-gynecology (OB-GYN) care include the Puerto Rican trials of oral contraceptive pills,[19] forced and coerced sterilization of Black, Indigenous, Puerto Rican, and Mexican American women,[20,21] and the extraction of Henrietta Lacks' cervical cells without her consent or knowledge.[22] This legacy continues to manifest, for example, in the forms of forced and coerced obstetric interventions, particularly cesarean births. The consequences are dire, especially for Black and other women and pregnant people of color.[23,24,25,26]

Frameworks Informing This Guide

Sexual and Reproductive Justice (SRJ), Birth Justice, and Intersectionality are anti-oppression frameworks that inform the NYC Standards and this guide. Oppression is defined as "unjust control and treatment; a system that maintains advantage and disadvantage based on social group memberships and operates on individual, institutional, and cultural levels."[27] These frameworks were developed by Black women activists, scholars, and advocates to dismantle systems of oppression, such as racism, sexism, heterosexism, and classism, and thereby ensure that everyone has access to the resources and support necessary to live healthy and fulfilling lives.

Sexual and Reproductive Justice (SRJ)

Reproductive Justice "combines reproductive rights and social justice."[28] Initially coined in 1994 by Women of African Descent for Reproductive Justice,** [29,30] it has been championed by SisterSong, "the largest national multi-ethnic Reproductive Justice collective," who define it as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[31]

*A system wherein African and African American people and their descendants were enslaved by European and European American people and made legally rendered personal property for the duration of their lives.

**By name, the "founding mothers" of Reproductive Justice are Toni M. Bond Leonard, Reverend Alma Crawford, Evelyn S. Field, Terri James, Bisola Marignay, Cassandra McConnell, Cynthia Newbille, Loretta Ross, Elizabeth Terry, 'Able' Mable Thomas, Winnette P. Willis, and Kim Youngblood.

Developed from this foundation, Sexual and Reproductive Justice is defined by the NYC Health Department to exist "when all people have the power and resources to make healthy decisions about their bodies, sexuality and reproduction."[32]

Birth Justice

In 2009, the Southern Birth Justice Network developed the Birth Justice framework and Bill of Rights from a term first known to be used by National Advocates for Pregnant Women.[33] Birth Justice exists when everyone has the freedom and support to make decisions about pregnancy, childbirth, and postpartum with dignity. This includes access to high-quality, culturally responsive care, freedom to choose where and with whom to give birth, and the ability to accept or decline medical interventions.[34,35]

Intersectionality

Intersectionality is "a theory, framework, analysis and practice of understanding the many identities and social realities that impact individuals and groups and their interactions with social institutions and different forms of power."[36] Intersectionality was coined by Kimberlé Crenshaw in 1989 and developed out of foundational Black feminist and Black lesbian feminist work, including the statement put forth by the Combahee River Collective in 1977 asserting, "we are actively committed to struggling against racial, sexual, heterosexual, and class oppression, and see as our particular task the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking."[37]

Purpose of This Guide

The purpose of this guide is to support those seeking to implement the NYC Standards by addressing the manifestations of institutional, organizational and personally mediated racism — root causes of racial and ethnic health inequities and disparities.[38,39,40,41,42,43,44] This guide offers recommendations to intervene against organizational and personally mediated racism and other forms of oppression and discrimination that occur in health settings and cause harm to Black, Latina, AAPI, and other women, as well as transgender and nonbinary pregnant, birthing, and parenting people of color.* The information in this guide is also designed to broadly improve care provision and promote health equity and birth equity by developing structural competency and humility (see definitions in the box below) within your practice.[45,46]

Health Equity and Birth Equity

Health equity exists when all people have the opportunity to achieve health and well-being, regardless of social position, location or identity. Dr. Joia Crear-Perry, Founder and President of the National Birth Equity Collaborative, defines birth equity as "the assurance of the conditions of optimal births for all people with a willingness to address racial and social inequalities in a sustained effort."[47]

*The language in this guide, such as "pregnant, birthing and postpartum people," is intended to inclusively recognize gender diversity among pregnant people, such as women, two-spirit people, transgender men, and people with nonbinary and other genders.

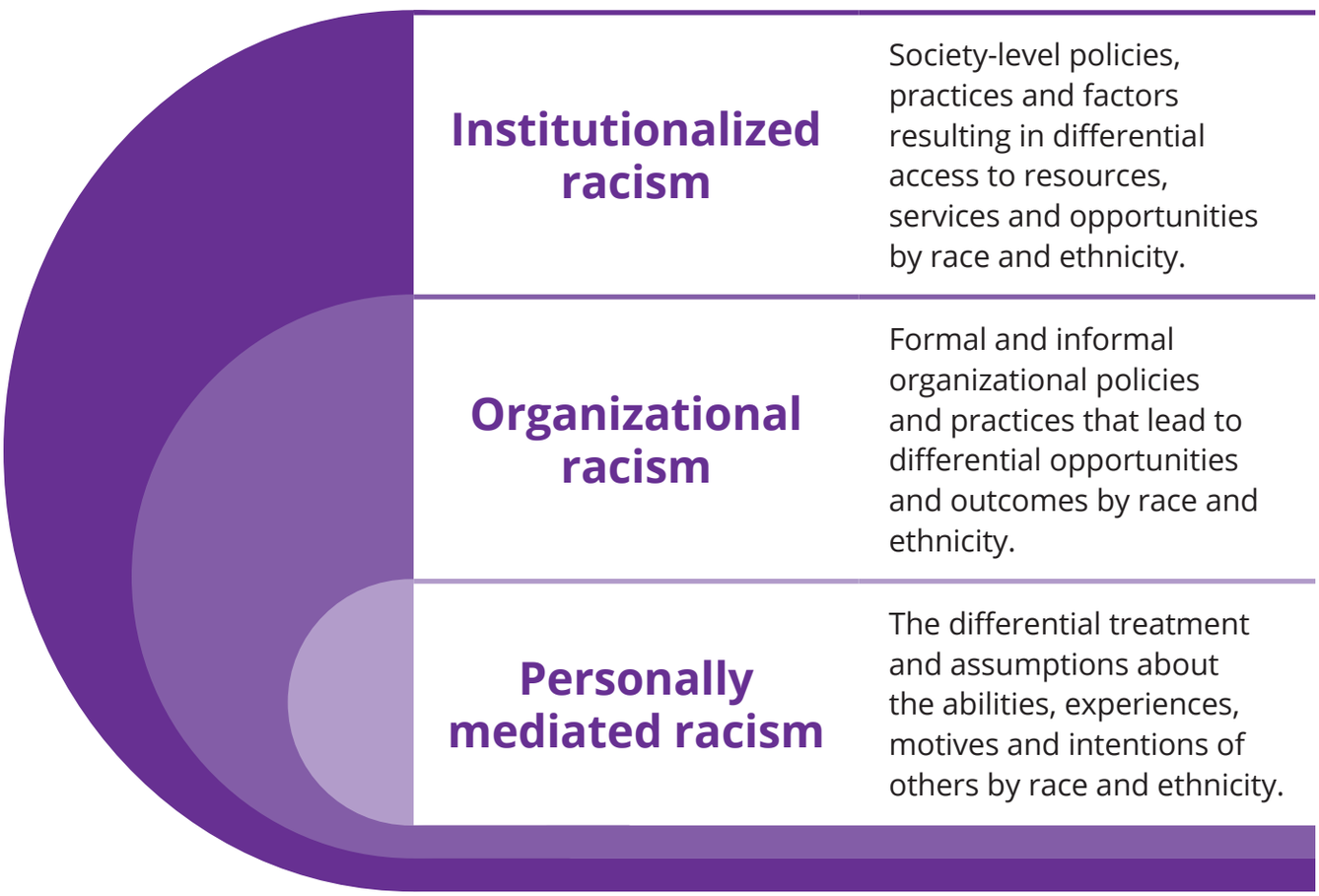
Structural Competency and Humility[48,49,50]

A structurally competent health care worker or site will:

1. Understand how legal, historical, social, and political contexts are shaping health and health care.
2. Recognize that health inequities result from inequitable contexts and intersecting structures of oppression — not an individual or group cultural shortcoming.
3. Cultivate humility by acknowledging patient expertise about their lived experiences as well as the limits of clinical knowledge and practice.
4. Use this knowledge to intervene in the production of inequities by supporting a person as they navigate structural constraints to achieving health and well-being.

See Also Appendix A, Introduction, Page 52, for related resources and trainings.

Levels of Racism*



*This framework is adapted and modified from the scholarship of Dr. Camara Phyllis Jones.[38,41]

Pregnancy During a Global Pandemic

Visit the NYC Health Department's COVID-19: Pregnancy webpage for resources to support pregnant, birthing, and postpartum people and their providers as they navigate new challenges and concerns brought about by the COVID-19 pandemic. Visit nyc.gov/health/coronavirus and click on Pregnancy, located on the left side of the page.

Who Should Read This Guide?

A variety of people contribute to pregnancy planning, prenatal, labor and delivery, and postpartum care in a variety of settings, including primary care clinics, specialty clinics, at home (with a midwife), community centers and groups, hospitals, and mental health groups. Every individual that interacts with the person seeking care contributes to care provision. In this guide, "provider" is used to refer to all health care workers who provide care, including nurses, nurse practitioners, midwives and doulas, physician assistants and physicians.

Implementation of the NYC Standards requires effort at all levels of health systems. Some of the strategies presented in this guide are intended for those providing clinical care; others require action at the site level. **If you contribute to care for pregnant and parenting people, this guide is for you.**

From patient service representatives and front desk clerks to nurses, midwives, physicians, doulas, and other birth workers, every person plays a role in providing respectful care at birth.

How to Use This Guide

This guide offers background information, resources, and guidance for implementing the NYC Standards. In the following sections, you will learn about key approaches foundational to the implementation of all Standards. The main chapters provide context followed by strategies to help you and your colleagues understand and implement individual Standards. You will be asked to follow links to view supplementary material, resources and tools located in appendices and online. Appendices contain resources to support your learning as well as tools to photocopy or print and share with patients. This guide is the product of years of collective work from community organizers, health care professionals, activists, academics, and representatives of community-based organizations (CBOs); everyone is encouraged to read it in full.

Approach

The following concepts and practices are foundational to the implementation of all of the NYC Standards.

Centered and Prioritized Communities

Community members that are centered within SRJ CEG work and this guide are disproportionately impacted by maternal, reproductive, and sexual health inequities, specifically those who are: Black, Latino/Latina, AAPI, and Native American; living

with HIV; Medicaid recipients; formerly incarcerated; people who use substances; and people who are undocumented immigrants. Within these centered communities, we further prioritized people with low incomes; lesbian, gay, bisexual, transgender, queer, intersex, and asexual people, and additional sexual and gender-diverse people including nonbinary and gender non-conforming people (LGBTQIA+); survivors of sexual and domestic violence; people with disabilities; people involved in the commercial sex industry; and people who do not speak English or have limited English proficiency.

Communication

The NYC Standards cannot be implemented without effective communication between pregnant or parenting people and members of their care teams. Effective communication practices grounded in structural competency and humility, Sexual and Reproductive Justice, Birth Justice, and intersectionality address oppression by mitigating power differentials between providers and patients.

Recommended Communication Strategies

Effective communication is a skill that requires ongoing practice, evaluation, and adjustment. To improve patient-provider communication, sites should routinely host individuals or organizations who offer anti-oppression and anti-racism training. Such trainings should be included as part of onboarding and annual competencies. Unaddressed racism, discrimination, and biases can lead to actions that are harmful to a patient's health and well-being, such as provider dismissal of symptoms, pain levels and health concerns, inappropriate suggestions, or language that conveys disregard for the person. **See Also** Appendix A, Introduction, Page 52, for resources on practicing and promoting anti-racism and Racial Justice in medicine. **Examples of organizations offering these trainings include: Advancing Health Equity, advancinghealthequity.com; Perception Institute, perception.org; AORTA, aorta.coop; and Race Forward, raceforward.org.**

To develop trust and respect in the patient-provider relationship, during interactions with pregnant, birthing, and postpartum people, we recommend providers:

1. **Include their name, pronouns, credentials, experience level, and any other professional information requested.**
2. **Model active listening by using attentive body language, such as eye contact, facing a person (not a screen), and asking for permission before touching a person.**
3. **Show empathy by expressing understanding of a person's situation, perspective, and feelings.**
4. **Be curious about a person's unique story without being intrusive: get to know a person's values, history, and health care goals.**
5. **Ensure access to and provide information in the person's preferred language.**

(continued on next page)

6. Actively listen by giving a person your undivided attention, hearing verbal and observing non-verbal communication, and reflecting back what you have heard and understood (and asking for more information when appropriate).
    a. If you have not understood, ask the person to tell you more.
    b. Ensure information shared by both parties has been understood before moving on.
7. Avoid medical jargon. Ask open-ended questions that allow for accurate assessments of a person's understanding of the treatment plan.
8. Encourage vocalization of questions and concerns by asking, "What questions do you have? How are you feeling about this information?"
9. Avoid providing too much information at once.
10. Do not assume silence indicates comprehension; pause often and check for questions or concerns if a person has been silent.
11. Establish patient preferences about communication early and often.
    a. Clearly and periodically ask about current phone numbers, whether it is okay to leave a voicemail, and health care proxies or surrogates with whom health information can be shared.
12. Consider communication when selecting personal protective equipment (PPE). For example, use masks with plastic panes to allow facial expressions to show.

Person-Centered Decision-Making (PCDM)

In PCDM, the agency, knowledge, and power of the person receiving care are prioritized. To effectively promote PCDM, the health care team must relinquish some of the power they possess in health care settings and interactions. The assessment of a person's values, goals, and preferences should happen before discussion of provider concerns or potential diagnoses. Providers should present thorough, unbiased information regarding a person's health in a language that is understood by the individual. Information should not be presented in a way that influences a person toward a particular decision or diminishes their role in the decision-making process, regardless of provider assumptions about the person's experience or capacity.[51] Information shared by providers should serve to increase the knowledge and power of the person receiving care.

From Shared to Person-Centered Decision-Making

PCDM advances models of shared decision-making (SDM) to maintain focus on the person receiving care. Despite offering valuable steps, SDM approaches often center a potential diagnosis or concern instead of the person seeking care, inadvertently marginalizing the experience of the pregnant, birthing, or parenting person.[52,53] Although revised models of SDM seek to address these issues,[54] PCDM ensures that a pregnant, birthing, or parenting person's beliefs, values, and goals and experiences are understood before decision-making begins.[55]

Trauma- and Resilience-Informed Systems (TRIS)

As a shared project of the NYC Health Department, the Maternity Hospital Quality Improvement Network (MHQIN), and Trauma Transformed, TRIS is designed to address racial disparities and institutional trauma in NYC maternity hospitals by building foundational knowledge about stress and trauma and promoting resilience at the level of health care systems. Portions of this guide will develop the capacity of individuals and sites to advance core principles of TRIS: reducing structural racism and bias; strengthening resilience; promoting safety and stability; cultivating compassion and trust; and fostering collaboration and agency.

Understanding the prevalence and impact of intimate partner violence (IPV) is critical to understanding trauma. IPV is defined as a range of coercive and abusive behaviors used by one partner to gain and maintain power and control over another partner. This can include people who are currently or formally romantic, dating, married, and/or have children in common, whether they are living together or apart. In the U.S., nearly half of female murder victims are killed by an intimate partner,[56] and more than one in four people have experienced rape, physical violence, and/or stalking by an intimate partner.[57] Homicide is a leading cause of death among pregnant and postpartum people.[58,59] It is essential that providers be aware of these risks, learn best practices to support people experiencing IPV, and center the experiences of pregnant and postpartum people within service delivery. **See Also** Support Tool 2, "Health Care Provider Guide for Supporting Pregnant People Experiencing Intimate Partner Violence (IPV)," Appendix B, Page 66, and Support Standards, Page 45.

Summary

Black, Latina, AAPI, and other women of color are more likely than White women to experience adverse perinatal outcomes in NYC. The SRJ CEG and the NYC Health Department created the NYC Standards as a key step toward the ultimate goal of eliminating racial and ethnic birth inequities in NYC. Health inequities are the result of interlocking systems of oppression that operate at multiple levels of society, providing differential access to optimal health and birth outcomes by race and ethnicity. Ensuring birth equity will therefore require the coordinated commitment and action of individuals, organizations, and communities. This guide intends to support you and your organization in your capacity to advance health equity. For your reference while reading these pages, the **NYC Standards for Respectful Care at Birth** appear on the inside cover at the front of this guide.

II. Education

Using effective communication to provide health education enhances patient autonomy, engagement, and self-efficacy (a person's belief they can succeed in a situation) and may improve health care outcomes.[60] Review options and limitations for care at your site with pregnant people early and often during first trimester individual or group prenatal sessions, intake, pregnancy confirmation visits, and tours of the birthing facility. **See Also** Introduction, Communication Strategies, Page 6.

EDUCATION STANDARD 1:

Pregnant, birthing, and postpartum people deserve to ask for and receive simple information that they can easily understand about obstetricians, gynecologists, nurses, midwives, doulas, or family medicine doctors, and their qualifications and professional experience.

Implementation Strategies

1. On your website and in informational brochures, list information about available health care professionals.
2. Routinely discuss with pregnant people the professionals they may encounter at your practice, whether they have the option to choose a particular provider or team of providers, and whether their involvement is optional (such as students or trainees).
    - Use the patient-facing document in Appendix B (**See Also** Education Tool 1, Page 60) to review health professionals that pregnant people may encounter.
3. If someone expresses interest in working with a professional not available at your site (for example, a midwife), ask questions to understand what kind of care the person is seeking and determine whether your site can provide an acceptable alternative. If not, make a referral for alternate care.

EDUCATION STANDARD 2:

Pregnant, birthing, and postpartum people deserve to ask for and receive simple information that they can easily understand about their options for where to give birth, such as a hospital, a birthing center, or their home.

Pregnant people may not be aware of the options and limitations for care at your site. Although people will ideally be aware of options for giving birth before enrolling in prenatal care, this information is not always easily available.

Implementation Strategies

1. Early in care, review options and limitations for birth care at your site with the pregnant person or family. **See Also** Education Standard 3, Page 10.
2. After learning a person's preferences along with relevant health factors, provide counseling about birth setting options. **See Also** PCDM, Page 7.
3. Hospital sites should maintain a current list of resources to share with pregnant people interested in non-hospital (for example, homebirth or freestanding birth center) settings.
4. Standardize a system for transitioning patients to external care sites.

Resources and Tools

1. For resources related to birth settings, including information about supervised homebirth, **See Also** Appendix A, Education Standard 2, Page 52.

EDUCATION STANDARD 3:

Pregnant, birthing, and postpartum people deserve to ask for and receive simple information that they can easily understand about the policies and practices of the place where they choose to give birth.

Although a provider or site cannot present every policy or practice, many — including those that encourage or limit family involvement or individual agency — can and should be reviewed with pregnant people.

Implementation Strategies

1. Early in care, ensure pregnant people are aware of site policies and practices related to:
    a. Admission criteria
    b. Number and type of support people who are welcome in the labor room or operating room, including whether doulas are supported
    c. Mobility, hydration, and nutrition during labor
    d. Fetal heart rate surveillance during labor, including whether intermittent monitoring is available
    e. Pain management options, including whether alternative pain relief measures such as ambulation are supported
    f. Availability and use of labor induction and augmentation
    g. Availability and use of cesarean
    h. Availability of trial of labor after cesarean (TOLAC, or a planned attempt to allow labor for pregnant people who had a previous cesarean)
2. Provide information about what constitutes low-, moderate-, and high-risk pregnancy and discuss related policies and practices with pregnant people. Also discuss common circumstances that may alter routine practices for low-risk pregnancies (for example, need for induction with premature rupture of membranes [PROM] with meconium-stained fluid).
3. Complete, distribute, and discuss the New York State (NYS) Department of Health's informational leaflet (health.ny.gov/publications/2901/index.htm) outlining annual site rates of select childbirth procedures, as required by NYS law. For details about the law, visit health.ny.gov and search for **Public Health Law Section 2803**.
4. Routinely share and review information about fees, insurance coverage for services, and financial assistance.
5. Publish site policies and practices, rates of select childbirth procedures, and financial information on your website.

EDUCATION STANDARD 4:

Pregnant, birthing, and postpartum people deserve to ask for and receive simple information that they can easily understand about resources to prepare for childbirth and feeding their baby, such as childbirth education classes and professional help with nursing.

Participation in childbirth preparation enhances a person's satisfaction with the childbearing experience and may increase the likelihood of vaginal birth.[61,62]

Breastfeeding and chestfeeding (see "Chestfeeding" box below) education and counseling for pregnant (and support) people during the antepartum period increases the likelihood that someone will choose to initiate and continue breastfeeding/chestfeeding.[63,64] Community and social network support also improves breastfeeding/chestfeeding outcomes.[65,66]

Chestfeeding

Some people use the term chestfeeding to describe the act of feeding their baby human milk (or chest milk) from their chest. Chestfeeding is an inclusive term, given that not everyone understands themselves to have "breasts," and not everyone is interested in or comfortable using the term "breastfeeding." Ask pregnant and postpartum people what term — whether breastfeeding, chestfeeding, or something else — feels best for them. Doing so promotes respectful care and may reduce barriers to chestfeeding for a variety of people, including people who are transgender and nonbinary and people who are survivors of sexual assault.[67]

Implementation Strategies

1. Offer free or sliding-scale childbirth preparation activities (in multiple languages) that:
   a. Deepen understanding of the labor process
   b. Reduce fear and anxiety related to laboring and birthing
   c. Offer techniques to cope with labor pain
   d. Improve communication with providers
2. Assess goals for infant feeding and provide anticipatory guidance on addressing common concerns.
3. Provide education on the benefits of breastfeeding/chestfeeding throughout the childbearing period (while engaging in PCDM). **See Also** Decision-Making Standard 3, Page 22, and "PCDM for Infant Feeding," Page 22.
4. If childbirth preparation or lactation support is not available at your site, then:
   a. Provide a list of local CBOs that serve expectant families: **See Also** Appendix A, Education Standard 4, Page 53, for a list of CBOs.
   b. Consider training staff to provide these services.
   c. Encourage CBOs to discuss their services with people in waiting areas, lobbies, during tours of the labor and delivery unit or during group prenatal care sessions.
   d. Consider holding a pregnancy and birth expo (a large exhibition) at your site to connect CBOs with expectant families and site employees.

Resources and Tools

1. Baby Friendly-USA® outlines important aspects of breastfeeding/chestfeeding education and support: babyfriendlyusa.org.
2. **See Also** Appendix A, Education Standard 4, Page 53, for resources on, and to learn more about, childbirth preparation and lactation support.

EDUCATION STANDARD 5:

Pregnant, birthing, and postpartum people deserve to ask for and receive simple information that they can easily understand about all possible outcomes of birth for them and their baby.

Implementation Strategies

1. Use the patient-facing document in Appendix B (**See Also** Education Tool 2, Page 62) to guide discussion of possible birth interventions and outcomes for a pregnant person and their fetus or newborn during prenatal visits, childbirth education classes, or tours of the childbirth facility.
2. During these discussions, review practices and policies specific to a provider, a site, and the health status and preferences of the pregnant person.

Resources and Tools

1. **See Also** Appendix A, Education Standard 5, Page 55, for additional resources to inform discussions with pregnant people about potential birth outcomes.

EDUCATION STANDARD 6:

Pregnant, birthing, and postpartum people deserve to ask for and receive simple information and referrals for benefits and services they may need, such as housing, food, legal support, and health insurance.

Sites must have the capacity to both identify health-related social needs and make appropriate referrals for benefits and services. Identifying needs without connection to services may result in frustration or harm to the individual, family, and health care relationship.

Implementation Strategies

1. Construct a database (or list) of site-vetted resources and services and standardized, documented referral pathways to those resources or services.
2. Dedicate on-site staff or provider hours to:
   a. Screen for social determinants of health (the conditions in places where people live, learn, work and play) and health-related social needs.
   b. Document needs in medical charts and ensure provider awareness of a person's needs.
   c. Assist pregnant people in obtaining benefits and services (for example, Special Supplemental Nutrition Program for Women, Infants, and Children [WIC], Supplemental Nutrition Assistance Program [SNAP], health insurance enrollment, legal services) during and after their pregnancy.
   d. Document referrals and follow-up using a standardized system.
3. Provide access to social/case workers when appropriate via standardized consultation pathways.

Assessing Social Determinants of Health

Use the following questions to begin assessing structural vulnerability, defined as "the risk that an individual experiences as a result of structural violence — including their location in multiple socioeconomic hierarchies."[68,*]

Financial security

- How do you make money?
- Do you run out of money at the end of the week or month?

Residence

- How long have you lived or stayed there?
- Is the place you live or stay clean/private/protected by a lease?

Food access

- What do you eat on most days?
- Do you have cooking facilities?

Education

- Can you read? In what language?
- What level of education have you reached?

Risk environments

- Are you exposed to violence?
- Are you scared to walk around your neighborhood?

Discrimination

- Have you experienced discrimination based on your skin color, gender or sexual orientation, or accent?

Resources and Tools

1. **See Also** Appendix A, Education Standard 6, Page 55, for screening tools and resources related to social determinants of health and health-related social needs.

*Adapted also from Dr. Uché Blackstock's presentation titled, "Structural Competency Meets Health Equity: Understanding How Structural Contexts Influence Health Outcomes." Presented June 2, 2020, to MHQIN.

III. Quality of Care

Quality care is equitable, person-centered, and not limited to the provision of safe and timely clinical care and interventions.[69,70] Identifying and eliminating disrespect, mistreatment, and abuse is often overlooked within assessments of quality obstetrical care.[71,72] Black people and other people of color, young people, and people with a Black partner are more likely to experience mistreatment in pregnancy, birthing, and postpartum care than their White counterparts,[73] contributing to racial and ethnic inequities in U.S. birth outcomes.[74,75,76,77,78] Protection from mistreatment, disrespect, and abuse are fundamental components of quality care.

To ensure the delivery of quality care at your site:

1. Designate staff to routinely measure, monitor, and respond to issues related to patient experience.
2. Routinely review and discuss measures of patient experience, such as Press Ganey scores, satisfaction surveys, comment cards, and grievance reports with all staff.
3. Standardize protocol and accountability measures to develop the capacity of providers and staff who receive negative feedback.
4. Gather an advisory board or patient experience committee comprised of former patients and community members to periodically meet and advise on childbirth care practices and issues pertaining to patient experiences.

QUALITY OF CARE STANDARD 1:

Pregnant, birthing, and postpartum people deserve the highest-quality health care. This includes timely attention to their needs, such as taking their pain level seriously, for their entire stay at a hospital or birthing center, or during the birthing experience at their home.

Providing timely attention to a person's needs during labor, childbirth, and postpartum requires regular assessment of their physical, emotional, and psychosocial well-being (**See Also** Communication Strategies, Introduction Page 6). Adequate and equitable pain management requires an understanding of a person's labor goals. Racial and ethnic inequities in pain assessment and management are well-documented and result from personally mediated and organizational racism.[79,80,81,82,83,84] Implementation of a holistic approach to pain care can reduce traumatic and inequitable birth experiences.

Implementation Strategies

1. Discuss labor pain during patient-provider visits and childbirth preparation activities so that the pregnant person, support people, and health care team develop an understanding of the pregnant person's expectations, values, and goals for coping with labor pain.
    a. Next, provide guidance in selecting well-matched options for coping with labor pain. **See Also** PCDM, Introduction Page 7.
2. Offer and allow a variety of alternative pain coping measures, for example: ambulation, position changes, birthing ball, aromatherapy, music, and so on.

3. Conduct standardized pain assessments for all patients upon admission, including an assessment of physical, emotional, and psychosocial well-being. Develop and enforce protocols for ongoing reassessment.

4. If a person reports pain, thoroughly review underlying causes to rule out complex conditions, such as preterm labor, preeclampsia, perineal trauma, infection, physical or sexual abuse, musculoskeletal injury, or other sources of acute or chronic pain.

5. Prioritize racial equity in the assessment and management of pain through staff trainings, monitoring pain assessment and management by patient race, and implementing quality improvement initiatives that promote racial equity.

A Holistic Approach to Pain Care:

- **Shifts focus from pain relief to coping with pain**
- **Centers a person's care goals**
- **Requires ongoing assessment of a person's experience of pain to determine whether or not they are suffering, regardless of "objective" pain level**
- **Can help ameliorate racial and gender disparities in pain assessment that stem from personally mediated racism**

Resources and Tools

1. Please read the box titled "A Holistic Approach to Pain Care."
2. Professional resources for pain management in labor care include:
   a. The Pain Management Preferences Scale (PMPS): a helpful tool to guide patient-provider conversations about coping with pain. For details, visit birthtools.org/Browse-Tools and type in the keywords **Clarifying Your Feelings About Pain and Medications in Childbirth**.
   b. Coping with Labor Algorithm®: For details, visit birthtools.org/Browse-Tools and type in the keywords **Coping with Labor Algorithm**.
   c. The American College of Obstetricians and Gynecologists (ACOG): Pain Management Resource Overview: acog.org/Womens-Health/Pain-Management
   d. The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN): Continuous Labor Support for Every Woman: jognn.org/article/S0884-2175(17)30482-3/fulltext

Disrespectful and Abusive Treatment

Disrespect and abuse (D&A), which is common in birthing institutions in the U.S. and across the globe, arises from inequities and unequal power dynamics within health care systems, communities, and care teams.[85,86,87,88] Mistreatment includes behaviors that are easily identified as physical abuse (such as slapping or restraining) and emotional and psychological abuse (for example, yelling, scolding, belittling, blaming). Other types of D&A include practices that are normalized yet may cause unnecessary harm, such as unnecessary episiotomy, forced or repeated pelvic examinations, tactics of coercion and separation from well newborn after birth. **See Also** Dignity and Nondiscrimination Standards, Page 32.

QUALITY OF CARE STANDARD 2:

Pregnant, birthing, and postpartum people deserve the highest-quality health care. This includes a safe and clean environment during their labor and delivery, and a quiet and safe room after they give birth.

Providing a safe environment for laboring people includes ensuring physical and emotional safety, protection from D&A, and protection from injury resulting from the action or inaction of the health care team.[89,90]

Implementation Strategies

1. Implement a trauma-and-resilience-informed systems approach to care. **See Also** TRIS, Introduction Page 8, and Appendix B, Support Tool 2, Page 66.
2. Promote a culture of safety by ensuring:
   a. Active involvement of pregnant people and their support people
   b. Effective communication between members of the health care team
   c. Respect for the contributions of all members of the team
   d. Adequate staffing
   e. Implementation of evidence-based systems to prevent overwork and fatigue[91,92]
3. Improve the physical environment and safety of a labor and birthing facility:
   a. Use private and semiprivate spaces for delivery and postpartum care.
   b. Encourage freedom of movement and support pain coping capacity by ensuring beds are not the center or focal point of a delivery room.[93,94]
   c. Encourage ambulation by providing a circuit of visual stimulation and small destination spaces for laboring people and their support people.[95,96]
   d. Formalize systems for high-importance communication with cleaning or environmental staff.
   e. Use signage to promote quiet hours throughout inpatient units.

Resources and Tools

1. To learn more about promoting a culture of safety, see:
    a. A Framework for Safe, Reliable, and Effective Care (Institute for Healthcare Improvement White Paper): ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx

QUALITY OF CARE STANDARD 3:

Pregnant, birthing, and postpartum people deserve the highest-quality health care. This includes providers who are trained and skilled in current best practices for care during pregnancy and childbirth.

Two extremes exist on the childbirth care continuum: "too much, too soon" and "too little, too late."[97] "Too little, too late" describes care withheld or delivered with insufficient resources or below evidence-based standards. "Too much, too soon" describes over-medicalized care, such as using non-evidence-based interventions or inappropriately or routinely using life-saving interventions. Either extreme can result in harm.[98]

Implementation Strategies

1. Ensure that providers and staff maintain skills and knowledge in line with current best practices by supporting employee continuing professional education and maintenance of certification and licensure programs.
2. Conduct ongoing performance improvement reviews with staff that incorporate patient experience feedback. Standardize approaches to implementing corrective action plans.
3. Implement system-level interventions demonstrated to enhance quality of care, teamwork and maternal health outcomes, such as:
    a. Grand rounds presentations
    b. Interprofessional training and simulation scenarios with assessment criteria for the provision of respectful, dignified, courteous, and unbiased care
    c. Regular review of unit policies and procedures that guide best practices
    d. Quality assessment teams
    e. Interprofessional site committees charged with examining and addressing inequitable patterns of care
    f. Maternal mortality review and benchmarking programs

Resources and Tools

1. Evidence-based practices resources:
   a. BirthTOOLS.org: Tools for Optimizing the Outcomes of Labor Safely
   b. ACOG: Approaches to Limit Intervention During Labor and Birth: Visit acog.org and search for **Approaches to Limit Intervention During Labor and Birth**.
2. System-level interventions:
   a. Alliance for Innovation on Maternal Health: small, straightforward sets of evidence-based practices that help providers improve outcomes across the health continuum. Visit saferbirth.org and select **patient safety bundles**.
   b. **See Also** Appendix A, Quality Standard 3, Page 58.

Routine Application of These Practices Is Not Evidenced-Based

- Episiotomy
- Limiting oral hydration in labor
- Continuous Electronic Fetal Monitoring (EFM)
- Confinement to bed during labor
- Directed pushing

Practices That Should Never Be Performed:

- Fundal pressure in second stage
- Restrained to bed in labor[99]

Caring for People Who Are Incarcerated

Shackling pregnant, laboring or birthing, and postpartum people who are incarcerated infringes on their human rights and introduces health risks (for example, injury from falling or restraint devices, delayed medical treatment, increased risk of complications, and interference with parent-newborn bonding and breastfeeding/chestfeeding).[100] New York law prohibits the shackling of people in labor, admitted to a hospital for delivery, and recovering from birth. Read the law in full: legislation.nysenate.gov/pdf/bills/2015/S983A. For guidance on providing respectful, dignified, and quality reproductive health care to people who are incarcerated, see Reproductive Injustice: The State of Reproductive Health Care for Women in NYS Prisons: static.prisonpolicy.org/scans/Reproductive-Injustice-FULL-REPORT-FINAL-2-11-15.pdf.

QUALITY OF CARE STANDARD 4:

Pregnant, birthing, and postpartum people deserve the highest-quality health care. This includes courteous staff who introduce themselves when they enter the room. If pregnant, birthing, and postpartum people have a negative experience or do not feel comfortable with a staff member for any reason (such as behavior, skill, or experience level), they can ask for and receive a different staff member.

Provider and staff introductions are key to establishing and maintaining respect and trust in the patient-provider relationship. This simple social exchange, which is fundamental to person-centered care, humanizes the person receiving care as well as the health care team.

Implementation Strategies

1. Providers and staff should introduce themselves upon entering a room or encountering a person in care.
    a. An introduction should include the provider or staff person's name, position, role in care, and gender pronouns.
2. Train every member of the care team in customer service for health care professionals and conflict resolution and de-escalation. Trainings should include skill-based assessments.
3. When a person is introduced to their health care team and site, providers should review members and categories of the health care personnel that may be involved in their care. **See Also** Education Standard 1, Page 9.
4. Students or trainees should share their status, background experience, and nature of involvement in care. Supervisors can introduce the student or trainee and initiate an informed consent* process with the patient for the student's or trainee's involvement.
    a. Permission for continued student or trainee involvement in care should be explicitly requested and granted, not assumed, regardless of care setting.
    b. This permission should not be obtained from a general informed consent form.
5. Discourage staff from entering a person's room unless they are a member of their direct care team, or assistance or urgent support is requested.

Resources and Tools

1. For guidance on sharing gender pronouns during introductions, **See Also** Dignity and Nondiscrimination Standards 5 and 6, Page 37.
2. For guidance on discussing the involvement of students or trainees with patients, **See Also** "Informed consent for participation of clinical health professional students" in Appendix C, Page 70.

*See Page 27 for the expansive definition of informed consent used in this guide.

IV. Decision-Making

PCDM (**See Also** PCDM, Introduction, Page 7) is a dynamic process requiring trust, respect, listening, dialogue, and time. Personal, social, and religious values, motivations and needs, along with prior personal or vicarious experiences influence desires and expectations for care and outcomes. The health care team can provide appropriate guidance and care only after ascertaining these factors.

Black and other pregnant, centered community members (**See Also** Centered and Prioritized Communities, Introduction, Page 5) are less likely to experience high-quality communication with members of their health care team, limiting their ability to participate in decision-making.[101,102,103,104] A pregnant person's participation in decision-making has a positive impact on their childbirth experience and satisfaction with care.[105,106] During each and every decision, pregnant, laboring, and postpartum people should be at the center of the decision-making process.

Strategies for Implementation of PCDM:[107,*]

1. Ask about care goals, preferences, and expectations.
2. Share different care options.
3. Explain the advantages and disadvantages of care options.
   See Also Informed Consent Standards, Page 27.
4. Ensure the person has understood all shared information.
5. Ensure the person has enough time to consider options.
6. Encourage the person to ask questions about care options.
7. Encourage the person to choose the care options they consider to be the best.
8. Support their choices.

DECISION-MAKING STANDARD 1:

Pregnant, birthing, and postpartum people deserve to decide what happens with their body and to make decisions for their baby. This includes making health care choices, such as which medical procedures they will and will not allow to be performed on them, based on their values, religion, and beliefs.

Pregnant people often think they are required to accept or comply with care recommendations,[108,109] and providers rarely use PCDM or an informed consent process for routine care (such as bloodwork) or examinations. Members of care teams are encouraged to use PCDM and an informed consent process for all procedures, tests, treatments, and drugs involving the patient or newborn — even if they are considered part of routine care. **See Also** Informed Consent Standards, Page 27.

*Modified from Vedal et al. 2017.

Why PCDM?

In one study, pregnant people who received counseling about management options for selected conditions received disproportionately more information about the intervention compared to the option of watchful waiting.[110] Those who received counseling on the intervention were also more likely to experience the intervention. This finding demonstrates the importance of PCDM and the provision of unbiased information.

Implementation Strategies:

1. Develop structural competency and humility rather than cultural competence (**See Also** Introduction, Page 1).[111]
    a. Structural competency and humility demand flexibility and openness to life-long learning, self-awareness, self-evaluation, and self-critique.[112] In contrast, becoming "culturally competent" — such as developing an awareness that those of the Jehovah's Witness faith may decline life-saving blood transfusions — suggests mastery of a finite body of knowledge and runs counter to PCDM.
2. Document and monitor social, religious, and cultural accommodation requests and fulfillment.
    a. Allocate resources to accommodate requests common to populations seeking care at your site (for example, gender of staff member, dietary practices, blood transfusion).
3. Use the Personalised Alternative Care and Treatment (PACT framework).[113]
    a. In the event of serious decisional conflict, review the options for care without using scare tactics. The PACT framework provides a structured approach that guides communication and documentation, prioritizes a pregnant person's autonomy, ensures continued access to health care, and supports the provision of respectful care even when decisional conflict arises.
    b. The health care team should reflect on whether their position is one of unnecessary paternalism (when someone in power imposes choices on someone, assuming it is in their supposed best interest) or whether there is a possibility of compromise on the part of the team.
    c. If no compromise can be achieved, the team should consult with colleagues or an ethics board to address unresolved health care plans. Threatening involvement of Child Protective Services (CPS) or other punitive measures to enforce medical compliance should be prohibited.

Resources and Tools

1. The PACT Framework: pubmed.ncbi.nlm.nih.gov/29605143/[114]

Language Assistance

When a pregnant person communicates through a second language, they may have limited resources to ask questions about health care recommendations.[115] Providers can promote PCDM by effective utilization of translation services in the person's preferred language and actively engaging the person in conversation. **See Also** Appendix C, Language Assistance, Page 71.

DECISION-MAKING STANDARD 2:

Pregnant, birthing, and postpartum people deserve to decide what happens with their body and to make decisions for their baby. This includes where to give birth, whether at a hospital, birthing center, or their home.

People who prefer out-of-hospital (OOH) birthing cite avoidance of intervention as well as discrimination and mistreatment as reasons for their preference.[116,117] Though the rates of interest in OOH appear to be similar among Black and White people, White people are more likely to plan a non-hospital birth, suggesting that Black people face disproportionate barriers to giving birth OOH.[118] **See Also** Education Standard 2, Page 9.

Implementation Strategies

1. Listen to a person's preferences, goals, and concerns related to birth locations.
2. Provide accurate, informative, bias-free information about how a person's health influences the relative safety of birth locations.
3. If a pregnant person desires but cannot access OOH birth, address the aspects of OOH birth that can be accommodated in a hospital setting. For example:
   a. Ambulation
   b. Access to intermittent fetal monitoring or auscultation as appropriate
   c. Limiting use of interventions unless medically necessary
   d. Oral rather than intravenous hydration, as appropriate.
   See Also Decision-Making Standard 6, Page 26.

DECISION-MAKING STANDARD 3:

Pregnant, birthing, and postpartum people deserve to decide what happens with their body and to make decisions for their baby. This includes choosing how to feed their baby — whether with breastfeeding/chestfeeding, formula, or a combination — and receiving the help they need to feed their baby.

Institutional, organizational, and personally mediated racism constrain Black people's access to the factors that facilitate breastfeeding/chestfeeding, resulting in low rates of human milk feeding among Black parents.[119] Pregnant and parenting people of color receive less information and guidance about breastfeeding/chestfeeding from providers than their White peers, driven in part by implicit and explicit provider bias and assumptions.[120] These inequities can be mitigated by ensuring equitable access to breastfeeding/chestfeeding information and support for pregnant and parenting Black people.

PCDM for Infant Feeding

- **Do not assume someone's choice for infant feeding.**
- **Do not begin the discussion with the message "breast is best."**
- **Do not limit the discussion to health benefits and risks.**
- **Do discuss infant feeding plans at multiple points during prenatal care.**
- **Do ask about prior infant feeding experience (personal, family, community).**
- **Do provide ongoing support or referrals for support of chosen infant feeding method.**

Implementation Strategies

1. Begin by understanding a person's values and goals regarding infant feeding and the postpartum period. Taking a public health approach to counseling on infant feeding (for example, "breast is best") may not be appropriate for all people.
2. Discuss a person's plans for infant feeding early and regularly.
    a. Understand the factors that contribute to decision-making, including bodily autonomy, sociocultural influences, gender, sexuality, trauma, and health concerns.
    b. Start where the person is:
        i. What is most important to you about choosing a way to feed your baby?
        ii. What have you heard about different ways to feed your baby?
        iii. Have you thought about or made a decision about your plan to feed your baby?
    c. Try to understand factors that influence their position:
        i. What things did you consider when making that decision?
        ii. What previous experience do you have with infant feeding?
    d. When a parent has a plan for infant feeding (formula feed, breastfeed/chestfeed, or a combination):
        i. Can I share some information about infant feeding options including possible benefits and limitations?
3. Document infant feeding decisions.
4. Ensure access to resources to support chosen feeding methods, such as free or sliding scale on-site classes or a list of CBOs and services to support various methods.
    a. Document and follow up on referrals to these services and resources.
5. Document and assess data regarding infant feeding support and care offered (in-house and referrals) by patient race and ethnicity.
6. Implement quality improvement plans for any identified inequities in support and care by race and ethnicity.

The Breastfeeding Mothers' Bill of Rights

In accordance with Article 28 of the NYS Public Health Law, hospitals are required to provide each patient or appointed support person a copy of the Breastfeeding Mothers' Bill of Rights: health.ny.gov/publications/2028.pdf

Resources and Tools

1. See Baby-Friendly USA® to learn about NYC hospitals designated as baby-friendly, as well as what makes a hospital baby-friendly: babyfriendlyusa.org
2. **See Also** Education Standards 4 and 6, Page 10 and Page 12.

DECISION-MAKING STANDARD 4:

Pregnant, birthing, and postpartum people deserve to decide what happens with their body and to make decisions for their baby. This includes holding their baby immediately after birth (also known as skin-to-skin), even if they have had a C-section.

Skin-to-skin contact (SSC) is the holding of an unclothed newborn to the bare chest by the birthing person, parent, or caretaker for a minimum of one hour after birth and until first infant feeding.[121,122] SSC performed immediately after vaginal or cesarean birth can provide emotional and physical benefits to the person and baby, including enhanced bonding and breastfeeding/chestfeeding, thermoregulation, neonatal vital sign stabilization, and improved parental satisfaction.[123,124,125,126,127] Unless an infant needs immediate or urgent medical attention, there is no justification to separate the newborn from a parent wishing for SSC.

Early newborn care practices often interfere unnecessarily with SSC and associated benefits.[128,129] Many routine newborn procedures (for example, birth weight, bath) can be initiated within six to 24 hours for well newborns and remain compliant with regulations or guidelines.[130,131,132] Eye prophylaxis and vitamin K can be administered during SSC; doing so may also

reduce newborn pain.[133] An implementation algorithm can be used to facilitate and improve the practice of SSC.[134]

Implementation Strategies

1. Develop policies and designate staff to support immediate, uninterrupted SSC for at least one hour (and as long as desired) after vaginal deliveries when desired by parent(s).
2. Offer and encourage the practice of "gentle cesarean model" to provide similar benefits.[135,136] This model includes SSC in addition to practices that may enhance the birthing experience, including:
    i. Attention to lighting
    ii. Delayed cord clamping
    iii. Presence of family members in the operating room
    iv. Direct sight lines from the birthing person to the newborn

3. Discuss SSC during the prenatal period.
4. Do not assume a person will want to participate in SSC. Do not shame or coerce parents into SSC, and do not place the infant on a person's abdomen after birth without obtaining consent.
5. Offer non-birthing parents the option of SSC.[137]
6. In the case of adoption, ideally the birthing person and adoptive parent(s) will together agree, in advance, whether and if so, who will practice SSC. Facilitate this decision between the relevant parties.

Resources and Tools

1. To implement an algorithm to improve SSC, see: ncbi.nlm.nih.gov/pmc/articles/PMC5900969/[138]

DECISION-MAKING STANDARD 5:

Pregnant, birthing, and postpartum people deserve to decide what happens with their body and to make decisions for their baby. This includes making choices about the care of their baby, such as whether or not to be with their baby for their baby's medical tests and procedures (unless there is a medical reason not to) and where their baby stays (in the same room with them or in the nursery).

For the most common procedures (such as newborn exam, circumcision of the penis), parental accompaniment is appropriate. Many routine procedures can be performed in the labor or postpartum room and do not require separation of parent and infant.

Implementation Strategies

1. Ensure that hospital policy requires comprehensive written and verbal informed consent of the people authorized to consent for minors* for all newborn tests, procedures, and treatments or drugs, including newborn toxicology testing.
2. Ensure documented procedures and designated staff to support dyad care, wherein noninvasive newborn tests can be conducted at bedside if desired by parent(s).
3. If a newborn must be transported for a procedure, the parent(s) should be able to accompany and provide comfort as desired.
4. If urgent care is needed that requires separation of the parent(s) and newborn, discuss the situation with the parent(s) and provide communication and support throughout the intervention.
5. Ensure policy and staff are in place to support 24-hour newborn rooming-in if desired by parent(s).
6. Routinely discuss the option of and alternatives to rooming-in with parents, eliciting and documenting preferences.

*As mandated by Public Health Law section 2504

DECISION-MAKING STANDARD 6:

Pregnant, birthing, and postpartum people deserve to decide what happens with their body and to make decisions for their baby. This includes having their decisions documented and that they understand associated possible risks.

"Birth plans" are designed to facilitate PCDM by sharing preferences, expectations, and goals a person has for pregnancy, labor, and birth. When a birth plan is accepted by a health care team as a communication tool and integrated into care, it may improve care, experience, satisfaction, and outcomes.[139,140] Unfortunately, birth plans have developed a problematic reputation among many providers.[141] To counter this bias, birth activists and professionals have promoted the use of "birth preferences."

Implementation Strategies

1. Encourage people developing birth plans/preferences documents to consider possible approaches to labor and birth care.
2. Before guiding a discussion about options, providers should explore their perception and tolerance of risk (bias) and that of the pregnant or birthing person, understanding they may not align.
3. Then, provide information about options that align most closely with a person's values and goals, sharing any risks associated with declining and undergoing examinations, procedures, and treatments.
4. The "teach back" method — when a person repeats back what they hear — is a helpful approach to ensure understanding of options and associated risks.
5. Once understanding is confirmed and a decision reached, document decisions in the record and share with the entire health care team. **See Also** Informed Consent Standards, Page 27.

Resources and Tools

- The California Maternal Quality Care Collaborative includes a birth plan template in their Toolkit to Support Vaginal Birth and Reduce Primary Cesareans.[142] A fillable PDF version can be downloaded at: cmqcc.org/content/appendix-e-birth-preferences-guide.

V. Informed Consent

Coercion in obstetric care is not a thing of the past (**See Also** Introduction, The Legacy of Racism in Sexual and Reproductive Health Care, Page 2; Dignity and Nondiscrimination Standards, Page 32). Medical coercion, including forced interventions as well as pressure, manipulation, and threats, are not uncommon in obstetric care. Black and other pregnant and parenting people of color experience obstetric coercion at higher rates than their White counterparts, contributing to stark inequities in birth outcomes.[143,144,145]

Informed consent is ethically paramount and legally required in health care settings for many procedures. The Joint Commission (a not-for-profit organization seeking to improve health care for the public) mandates documentation of all the elements of informed consent "in a form, progress notes, or elsewhere in the record."[146] NYS Law further states that people have the right to know and make informed choices regarding what is done to their bodies.[147] For the purposes of this guide, "informed consent" does not only refer to the written and verbal documentation processes required by law or your institution for limited aspects of care. Instead, informed consent is a more expansive concept: a person-centered decision-making process that ensures a person has unbiased, comprehensive information about benefits, risks and possible alternatives so they can make informed decisions about any and all aspects of their care. Informed consent should be sought for all tests, treatments or procedures, including:

- Anticipated testing
- Treatments and medications
- Procedures (for example, membrane stripping, cervical exams)
- Location and setting of delivery
- Possible situations and appropriate interventions when comprehensive or ideal informed consent may be more difficult to achieve (for example, need for emergency cesarean)

INFORMED CONSENT STANDARDS 1 AND 2:

Pregnant, birthing, and postpartum people deserve to know and make their own decisions about all of their medical procedures, test, treatments or drugs. Providers should share accurate, judgment-free explanations and information in a language pregnant, birthing, and postpartum people can understand so that they can make the decision that is right for them, when they are ready.

After they have made a decision, they have the right to change their mind and have their new decisions respected — even if their provider disagrees with them. Informed consent includes:

1. *Health care providers' recommendations about procedures, tests, treatments, or drugs*
2. *Any risks, benefits, and alternative procedures*

5 Elements to Informed Consent:

1. **The nature of the procedure, test, treatment, or drug.**
2. **The risks and benefits of the procedure/test/treatment/drug.**
3. **Reasonable alternatives.**
4. **Risks and benefits of alternatives.**
5. **Assessment of the person's understanding of elements 1 through 4.**

Implementation Strategies

1. Standardize information and protocol, such as forms, educational handouts, and language used to conduct informed consent conversations.
    a. Site approaches to informed consent should be easy to understand in patient-facing documents.
    b. Standardize protocol to respond to questions or concerns.
2. Identify, designate, and train care team members to initiate and follow up on comprehensive informed consent.
    a. Ensure that all providers are trained in comprehensive, SRJ-framed, person-centered informed consent protocol, including documentation.
    b. To minimize the risk of medical coercion, offer ongoing staff trainings on non-coercive informed consent counseling techniques.
    c. Consider designating an employee to specialize in informed consent delivery and standardizing delivery among providers at your site.
    d. Providers who will perform the intervention or an equivalent specialist should conduct final informed consent counseling for invasive interventions.
3. Ground informed consent conversations in a person's values, goals, and preferences, as well as contextual factors shaping their health and health care experience. **See Also** Structural Competency and Humility & PCDM, Introduction, Page 4 and Page 7.
4. Standardize timing and progression of informed consent conversations.
    a. Informed consent should begin at the very first visit, regardless of whether interventions and treatments might be considered "routine," "non-invasive," or "standard."
    b. Every time a provider makes a clinical decision, informed consent should be obtained in a language the person prefers and understands.
    c. Discussions about informed consent should be conducted at a reasonable time, when a person is awake, comfortable, alert, and receptive to information.
        i. Avoid obtaining consent when capacity to listen and retain information may be impaired, such as during painful contractions.

Racial Inequities in Toxicology Screenings and Reporting: The Importance of Informed Consent

Substance use during pregnancy should be met with supportive services, not punitive measures. Black and other women of color are more likely to be tested for substance use than White women[148,149,150,151,152] and — though positivity rates are similar — more likely to be reported to Child Protective Services.[153] Inequities in testing and reporting rates are driven by racism and undermine SRJ and Birth Justice by introducing incarceration, family separation, and termination of parental rights. Barring emergency exceptions, it is imperative that comprehensive written and verbal informed consent is obtained before conducting toxicology testing with pregnant, birthing, and postpartum people or their infants. At the time of writing, Bill No. S4821, which would make this policy the law and is supported by The Movement for Family Power (movementforfamilypower.org), is in committee in the NYS Senate. Refer to this bill and the Pregnancy and Substance Use Harm Reduction Toolkit from the National Harm Reduction Coalition (harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit) to ensure that best practices for toxicology testing are implemented at your site.

d. Whenever possible, provide ample time for a person to ask questions, consider options, and make an informed decision.

e. Address interventions and procedures that have a "point of no return" as early as appropriate.

f. Ensure that all staff are aware that decisions change and consent can be revoked at any time.

    i. Ensure that documented policies/procedures are in place to reach a resolution that centers patient autonomy in the case of decisional conflicts (for example, patients can sign a refusal of treatment/care).
    See Also Decision-Making Standards, Page 20.

g. In emergencies, when a decision must be made urgently, the person is not able to participate in decision-making and the person's surrogate is not available, physicians may initiate treatment without prior informed consent.

    i. In such situations, the physician should inform the person or surrogate at the earliest opportunity and obtain consent for ongoing treatment.

5. Address unequal patient-provider dynamics that hinder informed consent conversations.

a. Cultivate awareness of factors that may contribute to imbalances of power, such as race, ethnicity, class, gender, sexuality, immigration status, insurance status, religion, and preferred language.

i. Providers are in a privileged position within the patient-provider relationship. They have extensive training, education, and experience that most other people do not. It is important to keep this in mind when you are obtaining consent, as some people may not feel empowered to question or decline an "expert opinion" or advice.

ii. Avoid the use of medical jargon.

iii. Assume a physical position that is on the level of the person (such as seated by the bedside) and faces the person, not a screen, to avoid posturing that implies dominance or apathy.

iv. Hire providers whose race and ethnicity are concordant with community members who access your services.

v. Provide ongoing anti-oppression and anti-racism workshops and trainings and require iterative evaluations for all providers.

6. Assess the effectiveness of the exchange of information during discussions.

   a. Provide a written consent form that acknowledges a comprehensive discussion to formalize a person's informed consent for proposed care.

   b. Ensure availability of materials, including consent forms, in a language the patient prefers and understands.

   c. Ask the person to verbalize in their own words their understanding of the informed consent discussion, especially when a written form is not appropriate (for example, exams, intrapartum interventions).

   d. Encourage and take time to answer questions and clarify uncertainty.

7. Develop protocol and training to ensure people's decisions are upheld about what providers can be present during their childbirth experience. **See Also** Decision-Making Standards, Page 20.

   a. Share and discuss this protocol with the health care team and people receiving care.

   b. Address situations where other people may need to enter in emergency circumstances.

   c. Attend to the routine obtainment and documentation of verbal informed consent for the involvement of medical trainees in a person's care.

Resources and Tools

1. **See Also** Appendix B, Informed Consent Tool 1, Page 63, for a list of situations during triage, admission, labor and delivery, and postpartum where comprehensive informed consent processes should be initiated.

2. **See Also** Appendix C, Page 70, to read additional guidance on informed consent for participation of clinical health professional students.

3. Refer to the Reproductive Health Access Project's IUD Consent Form as an example of a consent script: reproductiveaccess.org/resource/iud-consent-form.

Obtaining Informed Consent Promotes Agency and Resilience

Many people have **histories of trauma, sexual or otherwise, that can be triggered by certain examinations or procedures** (**See Also** TRIS, Introduction, Page 8). People who have experienced sexual assault or abuse are more likely to experience pregnancy anxiety;[154] lack of power and control during pregnancy, childbirth, and related care can feel like a "reenactment of abuse."[155] Informed consent creates a safer care environment and increases feelings of agency, which leads to improved resilience and childbirth experiences among survivors of assault and abuse.[156,157,158]

Approaches to obtaining and documenting informed consent differ depending on the situation; informed consent for a repeat cesarean birth will be more time-intensive/in-depth than for prenatal genetic screening. A provider should not, however, make assumptions about what a person considers routine or invasive.

- **Example 1:** A 42-year-old woman presents for her annual gynecologic exam. During the exam, the provider performs a digital rectal exam. The person was only informed that she would receive a pelvic exam.
- **Example 2:** A 21-year-old woman comes to the clinic for her first pap smear. Her provider collects samples for sexually transmitted infections without asking or telling her.

It is necessary to obtain informed consent — accurate, judgment-free information regarding why a test is recommended as well as risks, benefits, and alternatives to the test/exam — so that a person can decide whether or not they want the test/exam. Performing a test or procedure (in the case of Example 2, a swab entering the body) without first obtaining consent may feel like a violation to the person and result in feeling a lack of control and agency in a clinical setting and ultimately harm.

In Example 1, informing the person about every component of the exam before she changes allows her to consent to or decline and anticipate each part of the exam. In Example 2, asking the person prior to the exam if she would like to have labs checked for sexually transmitted infection supports her agency and right to accept or decline. In both examples, stating what is about to be done before it is done informs the person what is about to happen to her body. This also allows her opportunities for control in an otherwise vulnerable situation, for example: requesting a pause or to defer part of the exam.

VI. Dignity and Nondiscrimination

A core tenet of the NYC Standards is treating pregnant, birthing, and postpartum people with dignity. As U.S. maternal mortality rates continue to rise, research into severe maternal morbidity and maternal mortality have documented numerous firsthand accounts of obstetric violence. Dr. Dána-Ain Davis defines obstetric violence as, "a form of gender-based violence experienced by people giving birth who are subjected to acts of violence that result in their being subordinated because they are obstetric patients," including "dehumanizing treatment and medical abuse such as birth rape, or violations experienced during childbearing."[159] **See Also** Disrespect and Abuse, Quality of Care Standards, Page 16.

Obstetric racism, which "lies at the intersection of obstetric violence and medical racism,"[160] is a driver of Black women's negative birth experiences, such as the dismissal of and inaction in response to their symptoms, leading to avoidable fatal or near-fatal consequences.[161] The racist concept that Black patients do not feel pain in the same way as White patients has been perpetuated throughout history; racially biased pain assessment and treatment continues to this day.[162]

The legacy of discriminatory and paternalistic treatment foundational to obstetric care in the U.S. influences reproductive care today (**See Also** Introduction, The Legacy of Racism in Sexual and Reproductive Health Care, Page 2). The recommendations below are designed to address the current crisis of unequal care provision underlying racial, ethnic, economic, and other inequities in birth outcomes in the U.S.

DIGNITY AND NONDISCRIMINATION STANDARD 1:

Pregnant, birthing, and postpartum people deserve to be treated with dignity and respect during pregnancy, during labor and childbirth, and after giving birth — no matter what. This means health care providers are expected to treat them and their family fairly, regardless of race, gender, religion, sexual orientation, age, disability, HIV status, immigration status, housing status, income level, or form of insurance.

NYC and New York State laws offer protection against many types of discrimination, and mandate the right to receive "treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age or source of payment."[163] The 2019 enactment of the Gender Expression Non-Discrimination Act (GENDA) newly protects transgender, gender nonconforming, and other individuals from discrimination on the basis of gender identity and expression. NYS law requires medical facilities to offer copies of and discuss the Patient Bill of Rights for Hospitals with each patient.[164]

Implementation Strategies

1. Sites should revise nondiscrimination policies and Patient Bill of Rights to cover all protected categories named within in the NYC Human Rights Law:
    a. Age
    b. Citizenship status
    c. Color
    d. Disability

e. Gender (including sexual harassment) and gender identity

f. Marital status and partnership status

g. National origin

h. Pregnancy and lactation accommodations

i. Race

j. Religion/creed

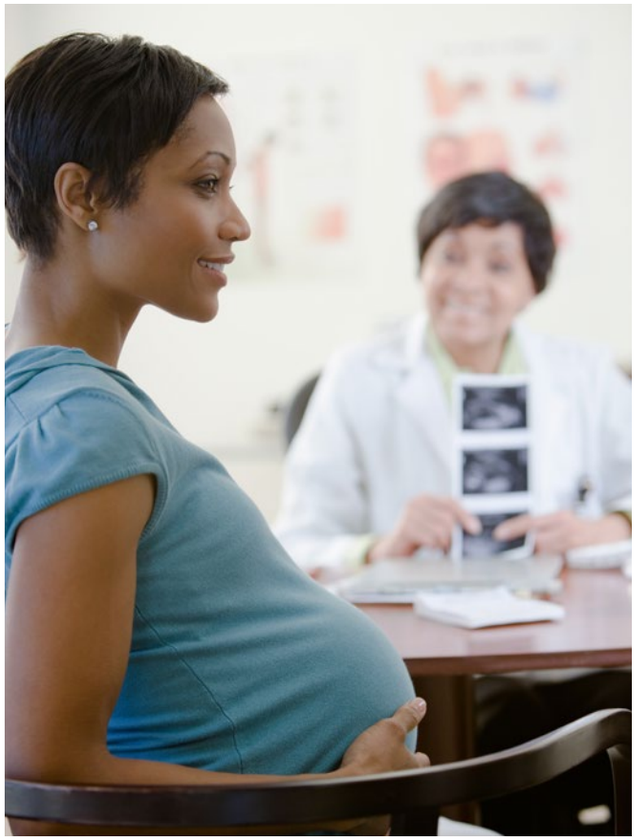
k. Sexual orientation

l. Status as a veteran or active military service member

m. Source of payment.

2. Require staff to review nondiscrimination policies annually and upon hire.

3. Make nondiscrimination policies available for staff to easily reference (for example, on hospital intranet, printed in binders, in staff manual).



4. Offer copies of nondiscrimination policies, written in a person's preferred language, in patient admission packets and at each appointment.

   a. Additionally, post them on the institution's website and in-patient areas within the facility (for example, exam rooms, waiting rooms, and bathrooms).

   b. Everywhere nondiscrimination policies are publicly available, include information about hospital, city (such as NYC Commission on Human Rights), and state discrimination reporting in multiple languages. **See Also** Dignity and Nondiscrimination Standard 8, Page 41.

5. In accordance with NYS law Section 405.7, subdivision (a) offer copies of and discuss the Patient Bill of Rights for Hospitals with each patient, as detailed in Section 405.7, subdivision (c).

6. Mandate staff training on racial, gender, and LGBTQIA+ equity and include competency assessments.

7. Formalize discrimination reporting mechanisms, including response and accountability protocol. Patients and staff should have the ability to anonymously report discrimination by hospital staff, as well as unsafe work environments.

8. Offer copies of the LGBTQ Health Care Bill of Rights and GENDA resources in exam rooms and patient waiting areas: nyc.gov/assets/doh/downloads/pdf/ah/lgbtq-bor-wallet.pdf.

Resources and Tools

1. Information regarding Patients' Bill of Right in NYS:
    a. NYS Department of Health's FAQs for Facilities Reproducing and Posting Patient Rights Publications: health.ny.gov/professionals/patients/patient_rights/docs/nyspbr_faqs.pdf
2. Guidance on developing institutional capacity to support Black pregnant, birthing, and postpartum people:
    a. Black Birthing Bill of Rights from the National Association to Advance Black Birth: thenaabb.org/index.php/black-birthing-bill-of-rights/
3. Guidance on addressing racial discrimination and harassment:
    a. Seattle Works Racial Grievance Policy: seattleworks.org/racialgrievancepolicy?layoutViewMode=tablet
4. The New York Transgender Advocacy Group holds free and public interactive, case-based trainings to inform participants how GENDA affects them and help develop toolkits to bring to their communities: nytag.org
5. Guidance on providing LGBTQIA+ affirming care:
    a. National LGBT Health Education Center: lgbtqiahealtheducation.org/wp-content/uploads/Providing-Inclusive-Services-and-Care-for-LGBT-People.pdf

DIGNITY AND NONDISCRIMINATION STANDARD 2:

Pregnant, birthing, and postpartum people deserve to be treated with dignity and respect during pregnancy, during labor and childbirth, and after giving birth — no matter what. This means health care providers are expected to provide an interpreter so that they can understand their health care provider, and their provider can understand them.

Effective communication is necessary to ensure that care provided is desired, understood, and accepted with comprehensive understanding and information. To support effective communication, people should have access to conversations, educational materials, and other language-based information received in clinical settings in their preferred language. Under Title VI of the Civil Rights Act of 1964, any hospital receiving public funding is required to provide language assistance services for their patients.[165] NYS law **section 405.7(a)(7)** similarly requires the provision of language assistance.

Hospital Challenges Meeting Language Assistance Standards

A study done by The Joint Commission noted that many hospitals lacked "defined policies and procedures for the provision of language services." To improve language access in hospitals, the Commission identified multiple areas for development, including: increased training on language services and communicating with interpreters; routine competency evaluations of people providing interpreter services; policies guiding the use of family members as interpreters; and expanded access to educational materials and health documents in a patient's preferred language. To access the complete report and recommendations, search the web for the PDF titled, "Hospitals, Language, and Culture: A Snapshot of the Nation" or type this URL into your browser: kyha.com/assets/docs/QualityDocs/EffectiveCommunications/jointcommissionpaper.pdf.

Implementation Strategies

1. Do not assume English is the preferred language of someone who speaks English: Ask all pregnant, birthing, and postpartum people for their preferred language.
2. Routinely assess languages spoken by people accessing your services and allocate resources accordingly.
3. Use interpreter services (through telephone or video or in person) and post educational materials in languages that serve the patient population.
4. Use interpretation devices available on mobile phones or tablets for quick access to interpreter services when patients are not near a stationary phone or need to be moved (such as in emergency situations).
5. Give multilingual providers language competency exams to ensure only certified staff are conducting visits in languages other than English.
6. Use a sticker or supplementary card on staff identification (ID) badges to indicate additional languages spoken.
7. Augment the allotted time for patient visits requiring interpreters to accommodate time necessary to interpret.
8. Add a required field in electronic medical records (EMRs) to document the reason interpreter services were not utilized when the patient's preferred language is documented as other than English (for example, staff member is qualified to speak in patient's preferred language). Routinely conduct chart audits to ensure interpreter services are utilized.

Resources and Tools

1. NYS requirements for hospital-based language assistance programs are detailed in NYS law Section 405.7(a)(7). For further guidance in this area, please refer to the "Language Assistance" resource in Appendix C, Page 71.
2. The enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (thinkculturalhealth.hhs.gov/clas) provide tools and guidance for health care professionals and organizations to improve language assistance services. For CLAS implantation guidance, see:
   - An Implementation Checklist for the National CLAS Standards: thinkculturalhealth.hhs.gov/assets/pdfs/AnImplementationChecklistfortheNationalCLASStandards.pdf
   - A Blueprint for Advancing and Sustaining CLAS Policy and Practice: thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf

DIGNITY AND NONDISCRIMINATION STANDARD 3:

Pregnant, birthing, and postpartum people deserve to be treated with dignity and respect during pregnancy, during labor and childbirth, and after giving birth — no matter what. This means health care providers are expected to protect their privacy and keep their medical information confidential.

Implementation Strategies

1. To comply with the federal Health Insurance Portability and Accountability Act (HIPAA) Security Rule, sites should utilize data protections like audit trails[166] and encryption in EMRs.
2. If a patient believes their HIPAA rights were violated or receive a breach notice, ensure they know how to file a complaint by visiting the U.S. Department of Health and Human Services (HHS) website.
3. Every one or two years assign free online video training modules to ensure new and established clinicians understand patients' rights to access their protected health information (PHI) and the HIPAA rules requiring providers to keep PHI safe.
4. Utilize HHS resources (see upcoming link), including online trainings and best practices on keeping PHI confidential.

Resources and Tools

1. See the HHS website for resources for professionals regarding federal HIPAA laws.
   a. Compiled best practices can be found here: healthit.gov/topic/privacy-security-and-hipaa/health-it-privacy-and-security-resources-providers
   b. Trainings can be found here: hhs.gov/hipaa/for-professionals/training/index.html
   c. Patients can report HIPAA violations here: hhs.gov/hipaa/filing-a-complaint/index.html

DIGNITY AND NONDISCRIMINATION STANDARD 4:

Pregnant, birthing, and postpartum people deserve to be treated with dignity and respect during pregnancy, during labor and childbirth, and after giving birth — no matter what. This means health care providers are expected to let them decide who they do and do not want in the room, including staff members, during exams and procedures, and to respect this decision.

Implementation Strategies

1. Providers in teaching hospitals should minimize the number of students in a room and obtain consent for student involvement in a patient's care, emphasizing that declining leads to no negative repercussions.
   See Also Quality of Care Standard 4, Page 19, and Appendix C, "Informed Consent for participation of clinical health professional students," Page 70.
2. Respect a person's decision to have support people, such as a doula, partner, family member or friend, in their room.
   See Also Support Standards, Page 43.

DIGNITY AND NONDISCRIMINATION STANDARDS 5 AND 6:

Pregnant, birthing, and postpartum people deserve to be treated with dignity and respect during pregnancy, during labor and childbirth, and after giving birth — no matter what. This means health care providers are expected to ask for and use the name and gender pronouns they prefer and use the name and gender pronouns they use to refer to their baby.

Gender and sex are distinct concepts with meanings that differ across social contexts. In Western societies, newborn sex is typically recorded on birth certificates as male or female following a superficial examination of genitalia (the determination and recording of "male" or "female" is called sex assigned at birth). Medical sex categorization further considers variations in hormone levels, internal and external sex organs, and chromosomes.[167] Intersex is a third term used when a person's anatomy does not fall on a distinct side of the medical sex categories of male and female.

Gender is a socially constructed set of characteristics, expectations, and expressions. Historically understood in the U.S. as binary categories (man/woman) linked to sex assigned at birth (male/female), additional categories and modalities[168] of gender exist, for example, people who are nonbinary, genderqueer, agender, and transgender. At the time of this guide's writing, 25 states — including New York — legally recognize a third gender. Gender identity (internally felt and therefore cannot be determined by an onlooker) can change over the course of a person's life.

People who are transgender and nonbinary routinely face discrimination, harassment, and D&A in health settings.[169,170,171] Perceiving that one's gender identity is misunderstood, rejected, disruptive, or stigmatized within in health settings often results in avoidance of health care services and, consequently, worsened health outcomes.[172,173,174] The time-sensitive nature of prenatal care makes health care avoidance especially risky.

People who are transgender and nonbinary are often told they cannot access health services because of false assumptions that they necessitate care from specially trained providers. **Turning a person away from your practice or site on the basis of gender identity or expression is against the law.**[175] Many people who are transgender and nonbinary are or will become parents through pregnancy.[176,177,178] From the moment a person presents for care — regardless of sex assigned on insurance or legal documents — one's gender and gender identity must be recognized and respected.

Implementation Strategies

1. Use neutral colors in newborn care as well as gender-inclusive language and visual cues.
2. Standardize and implement protocol for understanding, respecting, and affirming a person's gender.
    a. When you introduce yourself to a person, share the name and pronoun you would like used to address you.
    b. Ask a person's name and gender pronouns at the beginning of their first visit.
        i. Gender can change over time: Ask about names and pronouns in subsequent appointments as well.
    c. Offer in-depth training with competency assessments on LGBTQIA+ equity, including gender identity and expression, for all staff members.
    d. Encourage staff to wear buttons or stickers that display their gender pronouns wherever clinically appropriate.
    e. Ask people who are transgender and nonbinary about their preferences for receiving prenatal, birthing, and postpartum care that respects and affirms their gender (for example, preferred language to refer to their anatomy during exams and birth, preferred parental names). **See Also** PCDM, Introduction, Page 7, and Decision-Making Standards, Page 20).
        i. Document and respect preferences.
    f. Never ask questions about one's gender or body that are not necessary for the provision of respectful care (for example, do not ask "I'm curious, what made you decide to get surgery?").
3. Standardize collection and documentation of sexual orientation and gender identity (SOGI) information, including sexual orientation, sex assigned at birth, gender identity, and gender pronouns as well as preferred name.
    a. If EMR does not have a field for gender pronouns, contact the information technology (IT) service or EMR company to create it.
    b. Store SOGI information in easily accessible and viewable EMR fields.
    c. Include a write-in option for all questions.
    d. Encourage new patients to enter SOGI information in patient-facing portals prior to first visits.
    e. If left blank, collect SOGI information using on-site intake forms.
    f. If left blank, ask about and document SOGI information during initial visit.

g. Standardize workflow for when a person's intake information does not match insurance or legal documents.

   i. Designate someone on staff to liaise with labs or insurance companies as needed to ensure continuity of care.

4. Implement protocol for responding to complaints of discriminatory staff behavior based on sexual orientation, gender identity, or expression.

5. Ask what name and pronouns a person would like used when referring to their baby.

   a. Document this in the baby's medical records.

6. Create and implement protocol for accommodating requests to designate a baby's gender on the U.S. Standard Certificate of Live Birth as "undetermined."

   a. Ensure a person is aware of this option.

Some Examples of Gender Pronouns

- she/her/hers
- they/them/theirs
- he/him/his
- ze/zir/zirs[179]

Case Scenario: Sharing Names and Pronouns

A Certified Nursing Assistant (CNA) doing intake walks into the room:
Hello, my name is Nancy. I use she/her pronouns. I'll be doing your intake today.

Patient: Hi, Nancy. Nice to meet you.

CNA: Nice to meet you too! What name do you preferred to be called?

Patient: I usually go by Lisa instead of Alissa.

CNA: Okay, Lisa, thanks! **CNA notes preferred name in specified location in EMR** What pronouns would you like me to use when referring to you?

Patient: I don't understand what that means.

CNA: You know, instead of saying, "Nancy went to the store; Nancy bought some almonds," we could say, "Nancy went to the store; she got some almonds," or "he got some almonds" or "they got some almonds."

Patient: Oh! I use she.

CNA: Great, thanks. **CNA notes pronouns in EMR field**

Resources and Tools

1. Guidance on the usage of gender pronouns:
    a. Go to nyc.gov and search for **Gender Pronouns**.
    b. prideinpractice.org/wp-content/uploads/2019/05/Medical-Provider-Guide-to-Gender-Pronouns-Pride-in-Practice.pdf
2. Guidance on providing affirming care for people who are transgender and nonbinary:
    a. acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals
    b. lgbtqiahealtheducation.org/publication/affirmative-services-for-transgender-and-gender-diverse-people-best-practices-for-frontline-health-care-staff
3. Guidance on the collection and documentation of SOGI information:
    a. cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html
    b. Health Resources and Services Administration (HRSA): bphcdata.net/docs/uds_rep_instr.pdf
4. Guidance on prenatal, birthing, and postpartum care for transgender men:
    a. pubmed.ncbi.nlm.nih.gov/27030799/[180]
    b. ncbi.nlm.nih.gov/pmc/articles/PMC5688401/[181]
    c. ncbi.nlm.nih.gov/pmc/articles/PMC6814572/[182]

DIGNITY AND NONDISCRIMINATION STANDARD 7:

Pregnant, birthing, and postpartum people deserve to be treated with dignity and respect during pregnancy, during labor and childbirth, and after giving birth — no matter what. This means health care providers are expected to respect the decisions they have made about their family, such as whether they have a spouse or partner, what their spouse's or partner's gender is, how many children they have, or if they have chosen to place a baby for adoption.

People are the experts of their lives. Any decisions they make regarding their families is their own choice and must be honored and respected. Many of these decisions are explicitly protected categories in nondiscrimination laws.

Implementation Strategies

1. Standardize protocol to collect and document information about family structure in an inclusive way.
    a. Do not make assumptions surrounding the makeup of a person's family or support systems.
        i. Instead of asking discriminatory questions, such as "Will your baby's father be joining you in labor?" ask non-assuming questions, such as "Will any support people be present for labor?" **See Also** Dignity and Nondiscrimination Standard 1, Page 32, and 5 and 6, Page 37.
2. Revise visitation policy to allow a person to choose their support people. If restricted to one person, protect people's right to choose their support person (for example, same-gender partner, sister, friend).

3. Implement protocol for responding to complaints of discriminatory staff behavior based on sexual orientation, family structure, and/or adoption-related choices.

4. Offer specialized resources and referral systems (such as groups, case workers, and educational materials) for parents who chose adoption.

5. Ensure that signage and educational posters throughout the site include and reflect centered communities (**See Also** Centered Communities, Introduction, Page 5), for example, by featuring Black and other people of color and LGBTQIA+ people.

6. Support people who chose adoption.

    a. Ask and document preferences regarding:

        i) who will be present during labor, during birth and immediate postpartum; and

        ii) how much contact the birthing person prefers with the baby in the immediate postpartum.

    b. Designate member(s) of the care team to ensure that peoples' preferences are communicated with care team members and accommodated.

Resources and Tools

1. Guidance and further reading on care for lesbian, bisexual, and queer women:

    a. acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/05/health-care-for-lesbians-and-bisexual-women

    b. pubmed.ncbi.nlm.nih.gov/16466349/[183]

    c. pubmed.ncbi.nlm.nih.gov/17371524/[184]

    d. pubmed.ncbi.nlm.nih.gov/30973306/[185]

DIGNITY AND NONDISCRIMINATION STANDARD 8:

Pregnant, birthing, and postpartum people deserve to be treated with dignity and respect during pregnancy, during labor and childbirth, and after giving birth — no matter what. This means health care providers are expected to both acknowledge concerns or complaints that people may have about their health care and give them information about how to file a complaint about any aspect of care.

Implementation Strategies

1. Designate staff for grievance reporting and follow-up.

    a. Contact information for these staff should be easily accessible and posted in highly visible positions in exam, waiting rooms, and restrooms, and given directly to people when they initiate care.

    b. Post this information on the site webpage.

2. Standardize reporting and response protocols for patient grievances, including disciplinary actions for staff misconduct.
    a. Define timely follow-up (for example, within 48 hours of a filed grievance).
3. Staff and patients should be informed that outside of the site's internal reporting mechanisms, complaints can be filed with the NYC Commission on Human Rights and the NYS Department of Health.
    a. If a person believes they have been mistreated or denied care or services because of any protected class under the NYC Human Rights Law, they can call **311** or 718-722-3131 to file a complaint with the NYC Commission on Human Rights, or file a complaint online here: https://www1.nyc.gov/site/cchr/about/report-discrimination.page.
    b. Grievances can be filed with the NYS Department of Health by calling 800-804-5447 or filling out an online form at: health.ny.gov/regulations/discrimination_complaints.

VII. Support

SUPPORT STANDARDS

Utilizing dedicated support people such as family members, friends, and doulas during pregnancy, during labor and childbirth, and in the period after giving birth leads to a healthier pregnancy and more favorable birth outcomes. Continuous support during labor may have benefits such as decreased cesarean birth, shorter duration of labor, increased spontaneous vaginal birth, and decreased negative birth experiences.[186] In-room support takes many forms — people may request to bring their romantic partners, friends, family members, and doulas to care appointments and birth.[187]

Pregnant, birthing, and parenting people experiencing IPV, depression, and grief need additional forms of support. Staff need be aware of the high prevalence and impact of IPV (see information box with scenario, Page 48) and how to support those experiencing it. **See Also** Appendix B, Support Tool 2, Page 66.

Postpartum physical and mental health care is less likely to be delivered to Black and Latino parents compared to White parents;[188,189] follow-up visits that include screening for depression in the first three weeks followed by six weeks after birth are key to ensuring health equity.[190]

Loss, grief, and bereavement are also part of a pregnancy and birth. It is crucial for clinical practices to have resources to immediately support a grieving person and family, ensure long-term follow-up, and attend to vicarious trauma experienced by the care team.

SUPPORT STANDARD 1:

People deserve to receive support during pregnancy, during labor and childbirth, and after giving birth. This includes having the people they choose present during delivery and other procedures, such as their partner, family members, friends or doula (a trained professional who provides information and support during pregnancy, during labor and childbirth, and shortly after giving birth).

Implementation Strategies

1. Become a doula-friendly site (see information box on the next page).
2. Designate doulas as allied health professionals or care team members.
    a. State clearly in labor and delivery visitation policies that doulas are not to be counted as visitors.
3. Proactively share visitation policies and guidelines with patients as early in prenatal care as possible. **See Also** Decision-Making Standards, Page 20.
    a. At minimum, this discussion should include:
        i. Any restrictions on the number or age of visitors
        ii. Specifications regarding doula support

Become a Doula-Friendly Site

Doulas are trained childbirth professionals who provide "nonmedical physical, emotional, and informational support to childbearing people and their families" during pregnancy, during labor and childbirth, and after giving birth.[191] Doulas have emerged as a powerful source of support in many health care fields. Indigenous doulas have been shown to improve birth outcomes, as well as help redress "the westernization of childbirth," or the harmful consequences of the medicalization and removal of Indigenous culture from birth experiences.[192] Doula care is an important strategy to eliminate racial and ethnic inequities in birth outcomes. Community-based doula programs provide no-cost or low-cost care that promotes respect, human rights, self-determination, and health equity, tailored to meet the specific needs of the communities they serve.[193]

The NYC Coalition for Doula Access defines a doula-friendly hospital as one that:

- **Recognizes that the doula has been chosen by the client to be a part of the labor support team and includes the doula as part of the integrated team for the birth**
- **Allows the doula in the labor and delivery room, regardless of the number of allotted support people**
- **Ensures that the doula is treated with respect**
- **Understands that the doula supports the client and their desires**
- **Allows and supports nonmedical comfort techniques for labor, including but not limited to varied labor positions, movement, breathing techniques, aromatherapy, comforting touch, visualization, hydrotherapy, and the use of a birth ball or peanut ball**
- **Facilitates the provision of continuous, calming support by allowing the doula to be present in triage and, absent a compelling reason to the contrary, for procedures such as epidural insertion and cesarean section**
- **Ensures that the doula is able to support the client postpartum, while at the hospital, for breastfeeding/chestfeeding and additional comfort measures.[194]**

iii. Whether the site accommodates 24-hour visitation

iv. Security policies such as the need for visitors to show specific forms of ID

As early as possible, convey any reasons (medical or otherwise) for limiting the presence of support persons.

4. If the number of people in a room must be limited for safety reasons, prioritize the presence of support people over medical trainees.

5. Revise visitation policy to allow a person to choose their support people. If restricted to one person, protect people's right to choose their adult support person (for example, same-gender partner, sister, friend, spouse).

6. **Do not restrict access to a support person because of COVID-19.**
    a. Instead, provide PPE for support people.
    b. In case of future emergencies, ensure access to a support person (in addition to a doula, if desired).
7. Provide linkages to doulas and other community-based support services.
    a. Maintain and update a list of no-cost or low-cost doula services to share with patients who express interest in doula care. **See Also** patient-facing doula resources list in Appendix B, Support Tool 1, Page 65.
8. Ensure people have access to group pregnancy care. **See Also** Education Standard 4, Page 10.

Group Pregnancy Care

Group prenatal care is associated with lower rates of preterm birth and emergency visits in the third trimester, depressive symptoms, stress and social conflict, as well as higher rates of initiation and continuation of breastfeeding/chestfeeding, prenatal knowledge, satisfaction with care and self-esteem.[195,196,197,198] It is an important strategy for addressing racial inequities in preterm birth rates. Centering Pregnancy© is a copyrighted model of group care that professionals can be certified to implement. Sites can also develop their own curricula and models for group care.

Resources and Tools

1. The State of Doula Care in NYC 2019 from the NYC Health Department: nyc.gov/assets/doh/downloads/pdf/csi/doula-report-2019.pdf
2. ACOG's Committee on Obstetric Practice's opinion on Group Prenatal Care: acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/03/group-prenatal-care

SUPPORT STANDARD 2:

People deserve to receive support during pregnancy, during labor and childbirth, and after giving birth. This includes receiving information, counseling, and support services if they are experiencing intimate partner violence or depression after giving birth (also known as postpartum depression).

Implementation Strategies

1. At your site, consider implementing evidence-based approaches[199] to reduce birth and health risks associated with IPV.
    a. See "Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices": cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf
2. Ensure that staff are trained to identify and assess IPV. **See Also** the information boxes on the next pages, and Appendix B, Support Tool 2, Page 66.

3. Develop a prenatal panel or registry to monitor specific outcomes and metrics for pregnant, birthing, and postpartum people, including depression screening, referrals, and follow-up. Stratify data by patient race and ethnicity; identify and address any outcome or referral inequities.
4. Use validated tools such as the Edinburgh Postpartum Depression Scale (EDPS) and the Patient Health Questionnaire-9 (PHQ-9) to screen and diagnose for postpartum depression, anxiety, and suicidal ideation.
5. Ensure that all providers caring for postpartum people or their families are equipped to administer screeners and provide a follow-up plan for support and safety.
    a. If your clinic has pediatric services, coordinating visits may help streamline postpartum follow-up. Co-locating ambulatory postpartum and pediatric services eases coordination.
6. Explore how partners, who may also experience "baby blues," depression, or an adjustment reaction, are adjusting to changes.
    a. Ask about supports that are in place for the family or other loved ones (for example, community centers, churches, family therapy).
7. Implement a workflow for referrals to mental health services and follow up. Consider:
    a. Does the site have in-house behavioral health providers? Are there opportunities for "warm handoffs" (see sidebar)? If not, is there a quick-access resource guide for mental health resources in the community?
    b. If the clinic does not offer mental health services, or a person is seeking services that are not available at your clinic, explore their needs and connect them with the appropriate resource or person (such as a social worker; see upcoming resources provided).
8. Ensure all staff are familiar with and trained to implement protocol for mental health emergencies.
9. There are a variety of ways to encourage touchpoints for postpartum visits. Consider how billing works at your institution. "Early" postpartum visits can be primarily billed for issues such as breastfeeding/chestfeeding, blood pressure, and mental health, to avoid insurance complications or rejections of postpartum visits.

Warm Handoffs

The Agency for Healthcare Research and Quality describes a warm handoff as "a transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care." To learn how to implement warm handoffs, visit https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html.[200]

Abusive partners often try to limit their partner's control and agency over their sexual and reproductive health and rights.

Common abusive behaviors can include:

- Intimate Partner Sexual Violence: Any nonconsensual, forced or drug-facilitated sexual violence perpetrated by an intimate partner.
- Intentional transmission of sexually transmitted infections.
- Stealthing: a form of sexual assault which involves the act of nonconsensual condom removal.
- Reproductive control: a range of abusive behaviors that abusive partners use to pressure, coerce, or force their partner into becoming pregnant or into continuing or terminating a pregnancy, including:
  - Pregnancy pressure: pressuring or coercing a partner into becoming pregnant against their will.
  - Birth control sabotage: interfering with a partner's use of contraception to cause them to become pregnant against their will.
  - Pregnancy outcome control: pressuring or coercing a partner into continuing or ending a pregnancy against their will.
- Interfering with prenatal care.

Other abusive behaviors common during delivery and post-pregnancy:

- Influencing who is in the room during delivery
- Controlling the type and use of transportation
- Refusing to sign a birth certificate
- Interfering with postnatal care
- Threatening to contact child welfare
- Body-shaming

Resources and Tools

1. NYS Domestic Violence Chat/Text Hotline (Multilanguage Accessibility):
   - Supportive phone counseling, safety planning, and information and referrals for survivors, professionals, and concerned others regarding domestic and family violence, sexual violence, and elder abuse. Text at 844-997-2121 or go to opdv.ny.gov/survivors-victims and click **Chat live 24/7**. For deaf or hard of hearing, dial 711 to connect with an advocate.
   - People can also call **311** to connect with resources.
2. NYC Well provides free, confidential mental health support 24/7 via talk, text, and chat in more than 200 languages. This includes assistance accessing and scheduling mental health services. Patients can access this service at nyc.gov/nycwell, by calling 888-NYC-WELL (888-692-9355), or by texting "WELL" to 65173.
3. Visit nyc.gov/site/doh/health/health-topics/post-partum-depression.page to find postpartum-specific support options in NYC.
4. See mentalhealth.cityofnewyork.us/wp-content/uploads/2020/12/121420-LGBTQ-Guide-FINAL.pdf for LGBTQIA+ mental health resources.

IPV and Pregnancy: Case Scenario

1. **Victoria is a full-time college student with a child who is 3 years old. It has taken her longer to graduate because she left school during her first pregnancy. She is two months pregnant now. Brian is by her side during every medical appointment, just like he was with their first child. Is there any reason to suspect IPV?**
   - **A.** Yes
   - **B.** No
2. **Victoria expressed that she and Brian use condoms every time they have sex, so this pregnancy was a surprise. Brian knows that Victoria wanted to finish school before having more kids, and although she has thought about ending the pregnancy, she is scared. She does not feel like she has a choice. The last time she told Brian that she was apprehensive about continuing the pregnancy, he said she should "think twice about the consequences of her behavior." What are some indications that suggest Victoria may be a victim of IPV?**
   - **A.** Unintended pregnancy
   - **B.** Apprehensiveness about the pregnancy
   - **C.** Brian's response
   - **D.** A and C
   - **E.** All of the above

(continued on next page)

3. **Victoria's provider thought that Victoria may have been holding back during the visit and so asked Brian to step out of the room, telling him it had become clinic policy for providers to have a few minutes alone with the patient. Initially, he pushed back, stating that there are no secrets between the two of them. However, once he left, Victoria said she was confused. She said she loves Brian but, at the same time, this pregnancy was not planned. When asked if she wanted to consider other options she immediately shut down.**

   What should the provider do next?

   A. Ask Brian to talk with his wife about her options.
   B. Encourage Victoria to terminate the pregnancy.
   C. Encourage Victoria to continue the pregnancy.
   D. Offer additional resources.

1. **Answer: B (No).** We cannot assume that Victoria did not make the choice to become pregnant or that Brian's presence is not a sign of support.
2. **Answer: D (A and C).** Victoria's pregnancy appears to have been unintended, and Brian's response is indicative of reproductive violence — both indicators of IPV. People who have an unintended pregnancy are more likely to be in an abusive relationship than people who have a planned pregnancy.
3. **Answer: D (Offer additional resources).** People who experience IPV may not feel comfortable sharing their experience. The main goal of engaging patients around IPV should not be disclosure, but support and education on services. For information on how to support a pregnant person and what resources are available, **See Also** Appendix B, Support Tool 2, Page 66.

SUPPORT STANDARD 3:

People deserve to receive support during pregnancy, during labor and childbirth, and after giving birth. This includes receiving information, counseling, and support services for themselves and their family if they experience a miscarriage, stillbirth, or loss of an infant.

Implementation Strategies

1. Standardize protocol for responding to a fetal or neonatal loss.
   a. If your site does not provide a particular service or an acceptable alternative (for example, support groups, bereavement counseling, religious services), make a referral and direct patients to online resources, if helpful.
   b. The patient-facing checklist in Appendix B, Support Tool 3, Page 69, provides an overview of grief and bereavement services that may be offered at a site.

2. Biases influence how providers react to decisions and responses to grief and bereavement. Consider Alicia's Story (see upcoming sidebar).
    a. Decisions about pregnancy that involve loss and grief are difficult and should be honored as the person wishes.
    b. Use trainings to identify and mitigate provider views or biases regarding decisions related to pregnancy loss and grief.
    c. If inappropriate or biased comments or counseling are overheard by other care team members, they have a duty to immediately end it, address it, and report it.
        i. Ensure that all members of the care team know how to report unprofessional behavior.
    d. Consider conflict resolution trainings for all staff.
3. To manage vicarious trauma among providers (see Vicarious Trauma information box), implement a clinical practice that allows for group discussion about difficult or traumatic cases.
    a. Make mental health resources readily available for providers to anonymously self-refer and access.

Alicia's Story

Alicia is a 24-year-old who is pregnant and found out their fetus had significant abnormalities not compatible with life at their anatomy scan at 20 weeks. Alicia had to make a difficult decision: continue the pregnancy and wait for labor, or elect for a termination and delivery. Alicia opted for induced delivery of the non-viable fetus. This decision was painful, and they experienced a significant mental health crisis as a result. This was worsened by comments overheard by providers, referring to the fetus as a baby (against Alicia's wishes) and expressing shock that someone would end a pregnancy at 20 weeks, despite the reasoning. As a result, Alicia was admitted to the psychiatric ward for suicidal ideation and continues to require close mental health follow-up.

Resources and Tools

1. Postpartum Support International has general resources available for people grieving in the postpartum period: postpartum.net/get-help/loss-grief-in-pregnancy-postpartum.
2. Balint groups offer one model for diminishing vicarious trauma and developing resilience among providers by centering emotional and empathic responses in case reviews: americanbalintsociety.org.
3. The Center for Women's Mental Health at Massachusetts General Hospital provides mental health resources for providers and patients on an array of topics: womensmentalhealth.org/resource.

Vicarious trauma

The American Counseling Association defines vicarious trauma as "the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured."

Loss and grief not only impact the birthing person but can cause emotional anguish and vicarious trauma for providers.

Consider the following case. Dr. Stephanie was an attending physician who evaluated a person in triage, who came in after they did not feel their baby move for 24 hours. On ultrasound, there were no movements, respirations, or heartbeats. Dr. Stephanie shared this information with the person, who was understandably extremely upset, and continued to suffer from extreme grief for the duration of her hospitalization. Dr. Stephanie excused herself to cry after providing the information. She then took a deep breath and moved on to congratulate a new parent in the room down the hall.

This is likely a well-known experience for many providers. Providing care includes giving people bad news. As a result, providers experience trauma through the trauma of their patients — otherwise known as vicarious trauma. They also experience emotional pain through the pain of others. Not every provider is able to process these experiences with other providers, which can lead to higher rates of burnout, depression, and anxiety. For one model for staff support, see americanbalintsociety.org.

Thank you for doing your part to end racial and ethnic birth inequities.

Thank you for reading the main chapters of the **New York City Standards for Respectful Care at Birth Health Care Provider Resource Guide**. The NYC Standards and this guide are the products of years of collaboration between community members, activists, health care providers, health scholars, and NYC Health Department employees. This guide is a tool and resource to be used, revisited, referred back to as needed, and shared widely within your organization.

Learning from and implementing the recommendations presented in this guide will move us closer to ending racial and ethnic birth inequities in NYC. Thank you for your commitment to providing respectful care at birth, and for doing your part to advance health equity in our city.

VIII. Appendix A: Resources by Standard

Resources* by Standard for the New York City Standards for Respectful Care at Birth Health Care Provider Resource Guide

To find an electronic version of Appendix A and for more information and resources on implementing the Standards within your facility, visit nyc.gov/health and search for **Maternity Hospital Quality Improvement Network**.

Introduction

- National Birth Equity Collaborative: birthequity.org
- Resources and tools on anti-racism and racial justice in medicine:
  - Association of American Medical Colleges' Anti-racism in Medicine Collection: mededportal.org/anti-racism
  - Racial Justice Report Card, from White Coats for Black Lives: whitecoats4blacklives.org/rjrc
  - Racial Justice Assessment Tool: njjn.org/uploads/digital-library/AssessingOurOrganizations_RacialJustice%20(1)%20(1).pdf
  - Awake to Woke to Work: Building a Race Equity Culture: equityinthecenter.org/wp-content/uploads/2019/04/Equity-in-Center-Awake-Woke-Work-2019-final-1.pdf
  - Government Alliance on Race and Equity: racialequityalliance.org/tools-resources
  - Race Forward's Racial Justice Trainings: raceforward.org/trainings
- Resources and tools on implicit bias:
  - The Perception Institute: perception.org/research/implicit-bias
  - Project Implicit: implicit.harvard.edu/implicit
- Readings and training activities about structural competency and humility:
  - University At Albany School of Public Health: albany.edu/cphce/advancing_cc_webinar_aaseries_feb29.shtml
  - Jonathan M. Metzl: jonathanmetzl.com/structural-competency
  - American Medical Association (AMA) Journal of Ethics: journalofethics.ama-assn.org/article/structural-competency-and-reproductive-health/2018-03

Education: Standard 2

Resources on different birthing locations and birth workers for patients:

- Childbirth Connection provides resources for choosing a place of birth. Visit childbirthconnection.org/healthy-pregnancy/choosing-a-place-of-birth/resources.

*This list of services and resources is neither exclusive nor exhaustive. The NYC Health Department is providing this information to assist New Yorkers in locating services and general information but does not make any representation or warranty concerning the quality or accuracy of the services provided by these identified establishments.

- Baby-Friendly USA, Inc. provides an interactive map of hospitals that have the Baby-Friendly® designation. Visit babyfriendlyusa.org/for-parents/find-a-baby-friendly-facility.
- For a list of hospitals providing maternity care services, visit the New York State Department of Health website at health.ny.gov/statistics/facilities/hospital/maternity and select your county.
- For a list of accredited birthing centers in the NYC area, visit the American Association of Birth Centers (AABC) website at birthcenters.org and look for **Find a Birth Center**.
- For a list of homebirth midwives in the NYC area:
  - Visit the American College of Nurse-Midwives (ACNM) website at midwife.org and look for **Find a Midwife** or
  - Visit the NY Homebirth website at nyhomebirth.com and look for **Find a Midwife**.
- For an online directory that assists Black families with finding Black birth workers in their area, visit the Sista Midwife Productions website at sistamidwifedirectory.com.

Homebirth resources for health care professionals:

- The Midwives Alliance of North America outlines professional standards, competencies, and qualifications for midwives attending out-of-hospital birth, available at mana.org/about-midwives/professional-standards.
- The ACNM outlines core competencies and standards for midwives, available at midwife.org/ACNM-Documents.
- The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion No. 697 "Planned Home Birth" (April 2017) is available at acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/planned-home-birth.

Education: Standard 4

Resources for finding programs and services that offer childbirth and breastfeeding/chestfeeding education, counseling and postpartum support in NYC:

- The NYC Health Department's Guide to Breastfeeding Resources in NYC provides at-a-glance information on provided services (such as education, support, peer support and International Board-Certified Lactation Consultants [IBCLC]), available at nyc.gov/assets/doh/downloads/pdf/csi/csi-breastfeeding-hosp-resource.pdf.
- JustBirth Space is a nonclinical virtual perinatal support space for individuals in NYC and northern New Jersey for pregnancy, labor and birth, postpartum, and lactation and infant feeding support. JustBirth Space provides immediate support through text, in-depth support through phone or video, and communal support through a variety of weekly virtual community support groups. Visit justbirthspace.org.

- NYC Health Department Neighborhood Health Action Centers offer wellness programs for individuals and families, some of which are listed below. For more information, visit nyc.gov/health and search for **Neighborhood Health Action Centers**.
  - Baby Café USA provides breastfeeding and chestfeeding parents with high-quality lactation support. For more information on Baby Café USA, visit babycafeusa.org.
  - Family Wellness Suites provide services before, during and after pregnancy, such as childbirth education or parenting classes.
- Healthy Start programs offer free and confidential medical and social services for pregnant individuals and their families.
  - Bronx Healthy Start: Visit einsteinmed.org and search for **Bronx Healthy Start**.
  - Queens Healthy Start: Visit healthsolutions.org and search for **Queens Healthy Start**.
  - Healthy Start Brooklyn: Visit nyc.gov/health and search for **Healthy Start Brooklyn**.
  - Northern Manhattan Perinatal Partnership (Healthy Start Harlem): Visit nmppcares.org and select **Greater Harlem Healthy Start** under the Services drop-down.
- Additional resources on pregnancy and childbirth education and breastfeeding/chestfeeding:
  - The Bronx Health Link provides education workshops for pregnant people and their partners, available at bronxhealthlink.org.
  - The New York State Department of Health (NYSDOH) provides family support programs for pregnant and parenting families. For more information, visit health.ny.gov and search for **Pregnant or Parenting Families**.
  - Ancient Song Doula Services provides childbirth education classes. For more information, visit ancientsongdoulaservices.com/classes.
  - Mobile Milk, a text messaging campaign to encourage and support breastfeeding/chestfeeding. To get started, text "MILK" to 55676 or visit nyc.gov/health and search for **Texting**.
  - For a list of NYC Community Lactation Spaces, visit nyc.gov/health and search for **Find a Community Lactation Room**.
  - Black Mothers' Breastfeeding Association aims to reduce racial inequities in breastfeeding/chestfeeding success for Black families through direct service, education, and advocacy. For more information, visit blackmothersbreastfeeding.org.
  - To read the NYSDOH Breastfeeding Mothers' Bill of Rights (available in multiple languages), visit health.ny.gov and search for **Breastfeeding Mothers' Bill of Rights**.

- The New York Lactation Consultant Association seeks to help parents find higher-quality care and to enhance recognition of those providers who provide that care. For more information, visit nylca.org/standards.
- To read the NYC Mother's Guide to Breastfeeding, visit nyc.gov/health and search for **The NYC Mother's Guide to Breastfeeding**.
- The NYSDOH provides resources and information on breastfeeding promotion, protection, and support. Visit health.ny.gov and search for **breastfeeding**.
- The NYS Breastfeeding Coalition provides resources and information on breastfeeding promotion, protection, and support. Visit nysbreastfeeding.org and look for **Maternity Practices**.

Professional resources:

- The Academy of Breastfeeding Medicine Protocol #19: Breastfeeding Promotion in the Prenatal Setting, available at abm.memberclicks.net/assets/DOCUMENTS/PROTOCOLS/19-prenatal-setting-protocol-english.pdf.
- The Association of Women's Health and Neonatal Nurses Position Statement on Breastfeeding, available at onlinelibrary.wiley.com/doi/full/10.1111/1552-6909.12530.
- The ACNM Position Statement on Breastfeeding, available at https://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000248/Breastfeeding-statement-Feb-2016.pdf
- The ACOG Committee Opinion #756: Optimizing Support for Breastfeeding as Part of Obstetric Practice, available at acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/10/optimizing-support-for-breastfeeding-as-part-of-obstetric-practice.

Education: Standard 5

Resources to inform discussions with pregnant people about potential birth outcomes:

- The Journal of Midwifery & Women's Health provides a patient education handout on midwives, available at onlinelibrary.wiley.com/page/journal/15422011/homepage/midwifery.
- The ACOG provides patient education and resources on women's health, available at acog.org/patients.
- The Association of Women's Health Obstetric & Neonatal Nurses (AWHONN) provides patient education and resources on healthy pregnancy, healthy moms, and healthy babies, available at health4mom.org.

Education: Standard 6

Social determinants of health screening tools:

- The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) helps institutions and health care providers establish a data collection program to assess and respond to social determinants of health.

  - To learn more about PRAPARE, visit prapare.org and click on **Tools & Resources** to access the **PRAPARE Screening Tool** and the **PRAPARE Implementation and Action Toolkit**, along with webinars and other trainings and resources at this website.

- The Centers for Medicare & Medicaid Services developed the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to guide clinicians in developing treatment plans and making community referrals that take social needs into consideration, available at innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf.
- The EveryONE Project® by the American Academy of Family Physicians offers screening tools for assessing social needs:
  - View the Guide to Social Needs Screening at aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf.
  - View the Social Needs Screening Tool at:
    - Short Form (11 items): aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf
    - Long Form (15 items): aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-long-print.pdf

Additional screenings and resources for health-related social needs:

- access.nyc.gov
- View the NYSDOH's SDH/CBO Tool Kit, which includes several screening tools at health.ny.gov/health_care/medicaid/redesign/sdh/toolkit.htm.
- View the Center for Health Care Strategies' Social Determinants of Health Assessment Tools at chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/.
- View the Centers for Disease Control and Prevention's (CDC) Tools for Putting Social Determinants of Health into Action at cdc.gov/socialdeterminants/tools/index.htm.

Referring to government-supported benefits and services:

- Online self-prescreening is available to determine eligibility for various government-supported benefits including food assistance (Supplemental Nutrition Assistance Program [SNAP], the Special Supplemental Nutrition Program for Women, Infants and Children [WIC], school meal program, summer meal program); home energy assistance program (HEAP); health insurance and other temporary financial assistance. Visit mybenefits.ny.gov.

- Housing Assistance
  - In NYC, the Homelessness Prevention Administration (HPA), Department of Homeless Services (DHS), the NYC Housing Authority (NYCHA), and the Human Resources Administration (HRA) are responsible for helping people and families obtain and maintain affordable housing.
  - NYC offers a variety of rental assistance, eviction prevention, and homelessness prevention programs for those who are at risk. For more information, visit nyc.gov/hra and select **I Need Help**.
  - To apply for assistance, individuals need to visit a Department of Social Services Homebase or Housing Assistance Program office. For more information, visit nyc.gov/hra and search for **Homebase** or **Housing Assistance Program**.
  - The NYC Department of Social Services has developed a guide to assist those looking for housing and rental assistance, **Open Doors: Resources for New Yorkers Facing Housing Instability**. Visit nyc.gov/hra, select **I Need Help**, and select **Rental Assistance**.
- Food Assistance
  - Foodhelp.nyc.gov is an interactive map that helps find locations that offer free food (food pantries and soup kitchens) as well as grocery stores and farmers' markets throughout the five boroughs.
  - For more information on SNAP Benefits, visit nyc.gov/hra, select **I Need Help**, and select **SNAP Benefits**.
- WIC offers nutrition education, breastfeeding/chestfeeding support including securing a breast/chest pump, nutritious foods and referrals for those who are pregnant, postpartum, breastfeeding/chestfeeding or caregiving for children under the age of 5. To access the eligibility tool, visit wic.fns.usda.gov/wps/pages/preScreenTool.xhtml. For information on how to apply for WIC, visit health.ny.gov and search for **How do I apply for WIC**?
- Legal Support
  - Family Justice Centers of NYC provide social, legal, and criminal justice services for those who are victims or survivors of gender-based violence, human trafficking, stalking or interpersonal violence. For more information, visit nyc.gov and search for **Family Justice Centers**.
- Health Insurance
  - Pregnant people may seek out health care services before having access to insurance coverage. NY State of Health (nystateofhealth.ny.gov) is the official health plan marketplace for New York State. Consider familiarizing yourself with basic eligibility requirements and resources to offer appropriate information and referrals to pregnant and parenting people in your care.

- The NYS of Health provides at-a-glance cards in multiple languages about health insurance eligibility, coverage and projected cost for the following: **Medicaid**, **Essential Plan**, **Child Health Plus** and **Qualified Health Plan**. Visit nystateofhealth.ny.gov and search for **At a Glance Cards**.

A Note on Community-Based Organizations (CBOs)

There may be organizations in your local area that can assist families in accessing services. Consider making and maintaining a referral list of local CBOs. Familiarize yourself with local CBOs by reviewing their website or outreach materials to understand the kind of assistance or services they offer. Call or visit in person to explore what happens after a referral is made. Understanding the experience both practically (for example, if visitors are welcomed by a knowledgeable person on the phone or at the door) and procedurally (for example, if there are particular criteria for enrolling or accepting a person for assistance/services) can help you decide what CBOs are appropriate for referral. Consider organizing an annual CBO fair at your practice site to allow staff and patients to learn about local CBO offerings. Once you have a vetted list of organizations, verify and update it periodically to make sure contact and service information is accurate.

Points to consider when screening and selecting local CBOs for referrals:

- Does the group have a vision, a mission statement, or goals available to the public? If so, do they align with the potential needs of your practice population?
- Does the group include local community members as active participants in service provision (program development, peer roles, advisory groups)?
- Is the group affiliated with or supported by a faith-based organization? If so, do they provide assistance or services to individuals outside of their faith group?
- Does the group charge a fee for assistance or service? If so, do they offer a sliding scale or accept health insurance (if applicable)?
- Does the group have a formal referral system in place that you can use to facilitate a person's access to assistance or services? If so, is it optional or required?
- Can you refer patients directly to a specific staff person? If so, what is the best way for a pregnant/parenting person or family to reach the staff person?
- Does the group offer assistance and services in languages other than English? If so, which ones?
- Does the group offer assistance and services to people regardless of citizenship or residency status?

Quality: Standard 3

Professional resources for best practices:

- Approaches to Limit Intervention During Labor and Birth, Committee Opinion from ACOG, available at acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Approaches-to-Limit-Intervention-During-Labor-and-Birth.

- BirthTOOLS.org: Tools for Optimizing the Outcomes of Labor Safely. Visit birthtools.org.
- Clinical Guidelines for Obstetrical Services at CRICO-insured Institutions: Codification of best practices and recommendations from AAP, ACNM, ACOG, ASOA, available at rmf.harvard.edu/Risk-Prevention-and-Education/Guidelines-and-Algorithms-Catalog-Page.
- Evidence-Based Practice: Pearls of Midwifery is a free ACNM presentation to assist midwives and their supporters in explaining the midwifery model of maternity care. Visit midwife.org/pearls.
- Standardized Severe Maternal Morbidity Review: Rationale and Process: DOI:**10.1111/1552-6909.12478**
- World Health Organization recommendations: Intrapartum care for a positive childbirth experience, available at who.int/publications/i/item/9789241550215.

VIII. Appendix B: Tools

Education Tool 1: Definitions of Health Care Professionals

Midwives

Midwife – A health care provider with specialized training in sexual, reproductive, and childbearing care (pre-pregnancy, pregnancy, labor, birth, postpartum and newborn). In New York State (NYS) all midwives are Licensed Midwives (LM) and have a minimum of a master's degree. All LMs are board-certified (which means they pass certain tests to be able to practice) as Certified Midwives (CM) or Certified Nurse Midwives (CNM) if they also hold a degree in nursing.

Midwifery student – A person who is studying to become a midwife.

Nurses

Registered Nurse (RN) – A health professional who provides physical and emotional health care to patients and is licensed and registered in NYS. RNs must complete a nursing education program recognized by the State of New York and pass an exam to become licensed, then earn a bachelor's degree within 10 years of becoming licensed. Some have more training in specific areas and/or certifications to care for certain groups of people.

Nurse Manager – An RN who oversees how patients are cared for on a hospital unit (labor and delivery, postpartum). This includes how and what supplies are used, how other RNs provide care and how patients are moved in and out of hospital areas during their stay.

Nurse Practitioner (NP) – An advanced practice nurse who has specialized training to provide health care to certain groups of people. Nurse practitioners have a minimum of a master's degree. They are licensed and registered by NYS and may also be board-certified.

Nurse Practitioner student – An RN who is studying to become an NP.

Nursing student – A person who is studying to become a nurse.

Board-Certified Physicians

Anesthesiologist – A physician who specializes in giving medication for pain control (epidural, spinal, or general anesthesia) to people who request it during labor or to people who are giving birth by cesarean (also known as C-section). Anesthesiologists provide labor services in hospital. They do not work in birth centers or home birth settings. They are licensed by NYS and board-certified.

Attending Physician – A physician who oversees residents and medical students working in a hospital unit.

Family Medicine Physician – A physician who specializes in the care of families (newborns, children, adolescents, adults, older adults). They deliver babies but do not provide care during pregnancies with complications or medical problems (also known as high-risk pregnancies) or perform cesareans. They are licensed by NYS and are board-certified.

Neonatologist – A pediatrician who completes a fellowship to care for newborns, especially those who need intensive care. They are licensed by NYS and board-certified for special types of care.

Obstetrician – A physician who completed a residency training to specialize in sexual, reproductive, and childbearing care. Usually obstetricians are also gynecologists (OB/GYN). They are licensed by NYS and are board-certified.

Pediatrician – A physician who completed a residency training to specialize in caring for babies and children. They are licensed by NYS and might also be board-certified.

Perinatologist/Maternal Fetal Medicine Specialist – An obstetrician who completes a fellowship to care for pregnant people and their fetuses during high-risk pregnancies. They are licensed by NYS and are board-certified for special types of care.

Physicians-in-Training

Resident – A physician who has completed medical school and is in training to become a specialized physician. They are licensed as Medical Doctors (MDs) by NYS. In teaching hospitals and clinics family medicine residents, OB/GYN residents, and pediatric residents may provide care to the pregnant or laboring person and their family under the supervision of an attending physician.

Medical Student – A person who is studying to become a physician.

Other Health Care Professionals and Staff

Doula – A trained professional who provides physical and emotional support to individuals or families during pregnancy, labor, birth, and postpartum. Many doulas are trained by a doula organization and become certified in NYS, but doulas can practice in NYS without certification. Doulas are usually hired and paid for by the pregnant person. Some doula groups and some hospitals have low- or no-cost doulas for families who qualify.

Genetic Counselor – A health care professional with special training in medical genetics and counseling.

Lactation Consultant – A trained professional who helps a person with lactation (human milk production) and breastfeeding or chestfeeding. International Board-Certified Lactation consultants (IBCLCs) have special training and passed a specialized exam.

Registered Dieticians (RD) – A health care professional who completed special training to advise on diet and nutrition based on a person's current health and health goals. They have at least a master's degree and must be registered to practice in NYS.

Physician Assistant (PA) – A health care provider who works with a physician to give medical care. PAs have at least a master's degree. They are licensed and certified by NYS.

Social Worker – A trained professional who helps individuals and families with social and emotional care and services. They have a bachelor's degree (Bachelor of Social Work) and at least a master's degree. They are licensed by NYS.

Unit Clerk – A nonclinical person who works on a hospital unit. This person assists with patient registration and admission and helps schedule procedures. They may also be the person to answer the phone for the unit or give support people entry to a protected unit like labor and delivery or postpartum/newborn.

Education Tool 2: Definitions of Birth Terms

Vaginal birth – When the laboring person gives birth to the baby through the vagina using gravity and their own pushing efforts.

Unmedicated vaginal birth – Often referred to as a "natural birth"; occurs when the laboring person does not use analgesia (pain medication given by injection or IV) or anesthesia (epidural) to ease or block the pain of labor contractions. Note: Giving birth is a natural process whether or not medication is used.

Vaginal birth after cesarean birth (VBAC) – When the pregnant person gives birth vaginally after having given birth by cesarean in a previous pregnancy.

Vacuum-assisted vaginal birth – When a special strong suction cup is placed on the top of the baby's head and the birth care provider (usually a physician) pulls downward and outward during contractions and pushing to help the laboring person give birth.

Forceps-assisted vaginal birth – When a special tool called "forceps" is placed around the baby's head and the physician pulls downward and outward during contractions and pushing to help the laboring person give birth.

Episiotomy – A surgical cut of vaginal and perineal muscles and skin. Routine episiotomies (those done regularly without medical indication) are no longer considered appropriate.

Laceration – A tear of skin and/or muscle. A laceration occurring during birth can be repaired with stitches that dissolve over time and do not have to be removed. Local anesthetic, or numbing medication, is given by injection before stitches are placed.

Induction of labor – The use of medications to start your labor before it starts on its own.

Augmentation of labor – The use of medication (Pitocin) to continue labor when it has already started on its own but contractions and cervical dilation have slowed down or stopped.

Artificial rupture of membranes (AROM) – The intentional breaking of the amniotic sac (fluid-filled membrane sac surrounding the fetus during pregnancy), also known as "breaking the water." Your birth provider might recommend breaking the water as a way of starting labor or keeping labor moving.

Cesarean birth – Also referred to as "C-section," cesarean delivery or cesarean birth; occurs when the baby is born through an incision through the lower abdomen and uterus.

Primary cesarean – A person's first cesarean birth. Efforts to reduce overall cesarean rates are focused on reducing the numbers of primary cesarean sections that are not medically necessary.

Repeat cesarean – Any cesarean section after the first cesarean section.

Planned cesarean – Also known as an "elective cesarean"; a cesarean birth that is scheduled and performed before labor has begun. Scheduling a cesarean for convenience or for first time pregnant people is not recommended.

Intrapartum cesarean – Also known as an "emergency cesarean"; a cesarean birth that is performed when the pregnant person is already in labor.

Visit health.ny.gov/publications/2901/index.htm for more definitions.

Informed Consent Tool 1: Resource for Providers

The following list includes various topics during triage, admission, labor and delivery, and postpartum where a comprehensive informed consent (IC) process (see Page 27 for the expansive definition of informed consent used in this guide) should be initiated. While IC should be sought for all tests, treatments or procedures involving the patient, this list can assist providers in planning IC discussions around more common aspects of patient care.

1. **Triage:**
    a. Tests and procedures for "workup" of the presenting concern
    b. Decision for admission or discharge
2. **Admission:**
    a. Methods of induction and/or labor augmentation
    b. Potential time frame for induction and/or labor
    c. Methods for fetal and labor monitoring
    d. Admission labs and testing: What is included?
    e. Potential for operative vaginal birth
    f. Potential for cesarean birth
        i. Explain the most common reasons one may need this option.
    g. Potential for management of unforeseen complications (for example, hemorrhage, lacerations, hypertensive emergency or cord prolapse)
        i. This may be situational and provider-dependent, as discussing too many possible "bad outcomes" may cause anxiety or fear of labor and birth.
    h. Post-placental intrauterine device (IUD) insertion
        i. This consent should be obtained *only* if the patient has indicated that this is the method they want. If there is no contraceptive method documented in the chart, and the patient is unsure when asked, discussion about options should be done in a non-biased, non-coercive manner.
3. **Labor and Delivery:**
    a. Sterile vaginal and speculum exams
    b. Placement of urinary catheter
    c. Placement of a cervical ripening agent
        i. Review options or offer analgesia for potentially painful interventions (such as cervical foley).
    d. Rupture of membranes
    e. Placement of intrauterine pressure catheter

f. Placement of fetal scalp electrode

g. Initiating amnioinfusion

h. Maneuvers to rotate the fetal head with persistent occiput posterior

i. Varying labor positions (for example, due to changes in fetal heart rate, asynclitic engagement)

j. Beginning infusion of Pitocin

   i. Discuss how it is titrated, when it is increased/decreased/stopped, and potential side effects.

k. Directed pushing

l. Active management of the third stage of labor

   i. Delivery of the placenta: Explain what is happening and what you are doing.

   ii. Performing bimanual massage

   iii. Performing a "sweep" to remove clots

   iv. Placing a urinary catheter

m. Laceration repair

   i. Discuss type of laceration, type of repair required, and approximate length of time needed.

   ii. Ensure analgesia/anesthesia is appropriate, and continue to assess throughout the procedure.

4. Postpartum:

a. Contraceptive counseling

   i. Avoid coercive language.

   ii. Avoid "tiered" contraceptive counseling, focusing instead on factors important to the person (for example, having a period, having something inside the body, and so on).

   iii. Explain which options are available in-house, outpatient, or both.

   iv. Have the conversation when the patient is comfortable, alert, and receptive to discussing this topic (if at all).

b. Treatments related to possible complications

   i. Blood pressure medication

   ii. Visiting nurse coordination

c. Postpartum follow-up planning and decision about where to receive care after discharge

Support Tool 1: No-Cost and Low-Cost Doula Care

For current information about NYC's available no-cost and low-cost doula programs, visit nyc.gov/health/doula, scan the QR code, or call **311**. For more information about how NYC is promoting equity in maternal care, visit nyc.gov/health and search for Maternity Hospital Quality Improvement Network initiative. This initiative works with NYC maternity hospitals to prevent and reduce disparities in maternal mortality and severe maternal morbidity.

Support Tool 2: Health Care Provider Resource Guide for Supporting Pregnant People Experiencing Intimate Partner Violence (IPV)

A critical component of understanding stress and trauma is for health care providers to be aware of the high prevalence and impact of intimate partner violence (IPV), a range of coercive and abusive behaviors used by one partner to gain and maintain power and control over another partner. This awareness is particularly important when providing care to pregnant people, who are at greater risk of IPV. This guide shares best practices in engaging a pregnant patient about IPV.

The first step is creating the space for your patient to feel comfortable in sharing their experiences with IPV and for you to discuss available resources. Some sample language to do this could include:

- "Because many people experience relationship struggles, I now ask all of my patients about their relationships. The reason I ask is that I want to learn how I can best serve you. You do not have to answer any questions if you do not feel comfortable, but I can provide you information on resources if you are interested."
- "Thank you for sharing this with me. I am so sorry this is happening. What you are telling me makes me worry about your safety and health. A lot of my patients experience things like this and there are people who can help. I can connect you today if that interests you — even right now if you'd like."

Things to Consider

- For many people experiencing IPV, abuse can escalate during pregnancy.
- People experiencing IPV may also experience reproductive coercion.
- People causing harm often interfere with their partner's access to prenatal and postnatal care.
- You may not eliminate the abuse that the patient is experiencing, but you can help them mitigate the negative impact that the abuse is having on their health.
- Acknowledge treatment complications in the context of COVID-19, particularly for IPV survivors.

Respect Privacy and Confidentiality

- As a mandated reporter, explain your responsibilities such as limits on confidentiality.
- Before providing information on services, make sure it is safe for the patient to take documents with them.
  - If it is not safe, give them the option of using **311** to connect with resources.
- Do not discuss abuse when other people are present (unless that person is 18 months old or younger); instead, provide the patient with the opportunity to meet with you alone.
- Do not leave documents with information about abuse in public view.

Support Safety and Continuation of Care

- When scheduling appointments with the patient, ask them what is the best or safest time.
- Help the patient identify people who can support them during and after their pregnancy.
- Explore with the patient whether the abuse is impacting their access to prenatal and postnatal care.
- Ask whether there is anything that you can do to help them stay safe and continue accessing care.
- When asking questions about IPV, promote disclosure by acknowledging societal stigma, providing hypothetical examples, and avoiding loaded terms such as "abuse" in favor of more specific language.

Telehealth Best Practices

- Explore available platforms with the patient and allow them to choose what is safest for them.
- When safe communication has been established, consider coming up with a code the patient can use to let you know if it is no longer safe to continue the conversation.
- Recommend the patient use headphones for added privacy.
- Check periodically on whether the chosen platform is still safe, and plan for what to do if it is disrupted.
  - Consider offering the patient the option to contact you again when they are ready and in a safe and private location.

Respect the Patient's Right to Self-Determination

- Always engage with the patient using trauma-informed and person-centered practices:
  - Let the patient decide what is best for them, even if you disagree.
  - Offer options and support, not your opinion on what they should or should not do.
  - When providing information and resources, avoid saying "you should" and instead say "an option is."
  - Allow the patient to guide you on how you can support them.

Consider Your Role and Seek Support

- Understand and communicate the boundaries and expectations of your role to the patient.
- Seek guidance from and consult with supervisors, colleagues, and peers and identify additional resources, especially when presented with difficult cases.
  - For example, patients experiencing IPV could use assistance around safety planning, understanding health impacts, and connecting with additional resources.
- Be familiar with your organization's protocols on mandated reporting.

IPV Resources for Patients and Practitioners

NYS Domestic Violence Chat/Text Hotline (Multilanguage Accessibility)

- Supportive phone counseling, safety planning, and information and referrals for survivors, professionals, and concerned others regarding domestic or family violence, sexual violence, and elder abuse. Text at 844-997-2121 or chat at opdv.ny.gov. For deaf or hard of hearing, dial **711** to connect with an advocate.

NYC Domestic Violence Hotline

- For assistance with safety planning and access to the NYC Domestic Violence Shelters, contact NYC's 24/7 Domestic Violence Hotline at 800-621-HOPE (800-621-4673) or 866-604-5350 (TTY), or call **311**.

NYC Family Justice Centers (FJCs)

- For assistance and ongoing support, you can explore with your patient the NYC Family Justice Center location that is most convenient to them. NYC Family Justice Centers offer free and confidential help to survivors of IPV, sex trafficking, and elder abuse.
- As of January 2023, NYC FJCs are offering in-person appointments for services. Each location can be contacted Monday through Friday from 9 a.m. to 5 p.m. to connect clients to all FJC partners and services. If it is not safe or accessible for your patient to engage in virtual services, please contact the Manhattan FJC to schedule an in-person appointment.

Bronx Family Justice Center
198 E. 161st St., 2nd Floor
718-508-1220

Brooklyn Family Justice Center
350 Jay St., 15th Floor
718-250-5113

Manhattan Family Justice Center
80 Centre St., 5th Floor
212-602-2800

Queens Family Justice Center
126-02 82nd Ave.
718-575-4545

Staten Island Family Justice Center
126 Stuyvesant Pl., 1st Floor
718-697-4300

NYC HOPE

- **NYC Hope** is the City's online resource directory for information and resources about gender-based violence, including intimate partner and family violence, elder abuse, sexual assault, stalking, and human trafficking. Visit nyc.gov/nychope.

National Coalition Against Domestic Violence

- Provides an online safety planning tool and links to state coalitions. Visit ncadv.org.

Futures Without Violence

- Futures Without Violence is a health and social justice nonprofit with a simple mission: to heal those among us who are traumatized by violence today and to create healthy families and communities free of violence tomorrow. Visit futureswithoutviolence.org.

Support Tool 3: Bereavement and Grief Services Checklist

The items marked on this list are services available at:

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- ❑ Bereavement support and counseling:
  - ❑ Individual
  - ❑ Couple
  - ❑ Family
  - ❑ Phone-based counseling available
- ❑ Referrals for mental health and other support services
- ❑ Education and guidance regarding:
  - ❑ The grieving process
  - ❑ Helping siblings, partners, and other support people cope with loss
  - ❑ Developing healthy and effective coping strategies
- ❑ Support groups:
  - ❑ For individuals
  - ❑ For couples and families
  - ❑ Available in the preferred language of the clients
- ❑ Spiritual care services:
  - ❑ Interfaith chaplains
  - ❑ Interfaith chapel
  - ❑ Support for spiritual, cultural, or religious rituals that individuals and family members wish to participate in
- ❑ Dedicated bereavement care rooms or suites
- ❑ Cooling cribs to allow infants to stay with family
- ❑ Creation of mementos such as footprints or photographs
  - ❑ Available at no cost
  - ❑ Available at low cost or subsidized for people based on ability to pay
- ❑ Burial and cremation arrangements
  - ❑ Assistance with understanding options
  - ❑ Assistance with identifying and arranging services
  - ❑ Assistance with identifying funding sources as needed
- ❑ Assistance in accessing medical or community services
- ❑ Commemorative events:
  - ❑ Memorial services to commemorate those who were lost during pregnancy or infancy
  - ❑ Mother's and Father's Day services to honor parents who have lost children
  - ❑ Annual events such as walks and balloon releases.
- ❑ Additional services as described below:

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VIII. Appendix C: Supplementary Materials

Informed Consent*

Informed consent for participation of clinical health professional students

Many health care institutions work with clinical health professional student trainees, for example: student midwives, student nurses, medical students, physician assistant students, and resident and fellow physicians. Modeling appropriate consent for trainees will help develop person-centered, culturally humble, and compassionate providers.

Always seek a patient's informed consent to the presence or involvement of trainees prior to their involvement in a person's care. Creating systemic protocol around informed consent for trainee involvement in care can streamline care access and provision.

- **The involvement of trainees should be discussed with patients as early in care as possible.** Patients should be aware that they have the right to decline the involvement of student trainees. Inform patients what level (for example, post-graduate) of trainees are in the care setting. Declining or deferring involvement of residents will vary based on the structure of the care setting. Discuss student trainee involvement early on to allow time and consideration for birth location.
- **Informed consent for the involvement of trainees should be discussed with the patient by someone on the care team who is not a trainee and when the trainee is not in the room.** The presence of the trainee in the consent process may place undue stress or imply a lack of power in the decision-making process. The consent process should discuss the trainee's possible involvement in the patient's care (for example, observation, hands-on, assist), and to what level of involvement the patient is comfortable with. Document the patient's decision regarding the involvement of medical trainees in the patient's record.
- **Upon introduction to the patient, the trainee should restate their role (for example, a medical student) and confirm the patient's decision regarding involvement in their care.** This helps to reinforce the agency of the patient.
- **Patients have the right to change their decision at any time.**

*See Page 27 for the expansive definition of informed consent used in this guide.

Dignity and Nondiscrimination

Language Assistance

The Joint Commission offers the following recommendations for improving language access, guaranteed by Title VI of the Civil Rights Act of 1964* within federally funded health care facilities, in hospitals:**

- Make culturally and linguistically appropriate care highly visible to hospital staff and patients.
  - For example, include signage in multiple languages and include pictures and visuals to support those who may not read or write. Place images and symbols to represent access points for people to receive interpretation (for example, at the security desk, in the office).
- Implement a uniform framework for collecting data on race, ethnicity, and language.
- Provide ongoing in-service training on ways to meet the unique needs of patients, such as how and when to access language services for patients.
- Use health care interpreters to facilitate informed consent for all aspects of care involving patients with limited English proficiency.
- Develop relationships with and use cultural brokers as resources when patient cultural beliefs impact care.
- Implement written policies for the provision of language services.
  - Policies may include what language services are available, how to access these services, what to do if a patient refuses services, restricting the use of family members (especially minors), and how to establish competency and proficiency of people providing interpreter services.
- Incorporate language service programs into safety and quality improvement efforts.
- Assess, utilize, and partner with local resources and organizations to support language proficiency and access, and cultural humility.

Additional ideas include:

- Ask and document a person's preferred language at their initial visit. Confirm their preference at each follow-up visit or encounter.
  - When a language other than English is selected, check to make sure interpreter services were offered for the current and past visits.
  - Translation takes time. Make sure patients with language access needs are given enough time with providers (for example, 30 minutes instead of 15 minutes).

*Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency. Office for Civil Rights, U.S. Department of Health and Human Services. August 30, 2000. https://www.federalregister.gov/d/00-22140

Visit jointcommission.org and search for **patient-centered communication resources to find the **Language Access Hospital and Hospital Clinics** report titled, **Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals**.

- Run "panel reports" to assess what languages are spoken by people accessing services within each clinical setting.
- Become a linguistically inclusive institution: hire staff at all levels who reflect and speak the languages of the communities served.
  - To do so, enhance Human Resources recruitment efforts and provide incentives for staff to learn and use a second language.
- Implement the use of language services protocols into clinic workflows.
- Find, offer, and encourage staff to complete continuing education units about language access and cultural humility and responsiveness.
- Make sure that all printed materials and signage are written at a basic literacy level — 6th grade or lower.
- Report near-misses and adverse events involving issues with access to language and culture services and develop guidance and protocols around reporting these data.
- See also AAMC Guidelines for Use of Medical Interpreter Services, available at aamc.org/system/files/c/2/70338-interpreter-guidelines.pdf.

Assessing Language Competency

There is a national movement to develop a standardized practice for assessing the competency of any individual providing interpreter services. Medical interpreters generally go through evaluation and certification processes. To meet the National Culturally and Linguistically Appropriate Services (CLAS) Standard for language services,* evaluate staff who offer to provide interpreter services for patient care for language competency — specifically regarding medical language. To ease identification and access of support, outwardly identify those who have attained a certain level of language of competency and passed an evaluation or certification.

If institutional resources cannot support this recommendation, assess each provider's language proficiency and comfort with interpreting in a medical setting using The American Council on the Teaching of Foreign Languages (ACTFL) language proficiency guidelines, available at actfl.org/sites/default/files/guidelines/ACTFLProficiencyGuidelines2012.pdf.

Although there are no formal recommendations regarding noncertified interpretation, consider a minimum of Intermediate-High/Advanced-Low proficiency, per the ACTFL language proficiency guidelines, when deciding whether to move forward with a noncertified interpreter.

*National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for advancing and Sustaining CLAS Policy and Practice. Office of Minority Health, U.S. Department of Health and Human Services. April 2013. https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf

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