Let’s Build Something Together: Insights from the Community Birth Partnership Initiative

A project of the California Maternal Quality Care Collaborative

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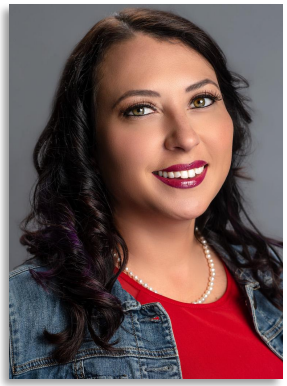
Let's Build Something Together: Insights from the Community Birth Partnership Initiative

Presenters



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Welcome and FAQs

- **All participants are muted and the chat function has been disabled.**
- **Will this webinar be recorded? Will the slides be available?**
  - YES. Both the recording and slides will be available within 1 week on the CMQCC webpage: https://www.cmqcc.org/toolkits-quality-improvement/community-birth-partnership-initiative
- **You are welcome to use any of the slides provided for educational purposes. If you modify or add a slide, please substitute your institutional logo and do not use the CMQCC logos.**
- **How do I ask questions?**
  - During this webinar, you may drop your questions into the Q&A box at any time. Presenters will write out answers to your questions during the webinar.
  - If you have remaining questions after the webinar, please email christawalczak@stanford.edu and the team would be happy to follow-up with an answer.

Objectives

- Understand the goals and insights from the Community Birth Partnership Initiative (CBPI) pilot project.
- Identify best practices for hospitals, community midwives, and EMS to strengthen collaboration and improve transfers across birth settings.

Disclosure: This slide set is considered an educational resource but does not define the standard of care in California or elsewhere. Readers are advised to adapt the guidelines and resources based on their local facility's level of care and patient populations served and are also advised to not rely solely on the guidelines presented here.

Community Birth Partnership Initiative: A Strategy to Improve Outcomes

Mission of the CBPI:

- To improve health outcomes during pregnancy and birth by increasing the quality and whole-person safety of hospital transfer processes, when a transfer is needed for a community birth.
- To enhance integration between perinatal care systems that have traditionally worked in isolation from each other in California, focusing on our *shared responsibility* (hospital, community midwives, and EMS) to improve outcomes.

The Community Birth Partnership Initiative and the Toolkit presented today has been funded by the Skyline Foundation

Why Focus on Community Birth?

When considering improvement in the birth space, ALL birth care settings must be included

"...Excluding planned community births,[5] those intended to take place either at home or in a freestanding birth center, from quality collaboratives provides an incomplete picture of birth in the United States. It also limits the opportunities to promote greater integration of maternity care across all settings and providers, expand care options for childbearing families, and generate much-needed quality improvement across the full spectrum of care."

Levine, A., Souter, V. and Sakala, C. (2022), Are perinatal quality collaboratives collaborating enough? How including all birth settings can drive needed improvement in the United States maternity care system. Birth, 49: 3-10. https://doi.org/10.1111/birt.12600

Integration of Birth Care Providers and Systems Increases our Chance of Success

A more integrated system is safer and can address other opportunities

Health Equity

- Patient Autonomy
- Cultural Preferences
- Prior Birth Trauma

Data Completeness

- Informed decisions about provider & setting
- Interprofessional learning to better meet patients' needs and address shared quality interests

Hospital Closures

- Supports access to care
- Emergency Medical Services

BIRTH ISSUES IN PERINATAL CARE

COMMENTARY | Open Access

Are perinatal quality collaboratives collaborating enough? How including all birth settings can drive needed improvement in the United States maternity care system

Audrey Levine BA, LM, CPM-retired, Vivienne Souter MD, Carol Sakala PhD, MSPH

First published: 26 October 2021 | https://doi.org/10.1111/birt.12600 | VIEW

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Clinical Information › Policy & Position Statements › Position Statements › Transfer Protocols for Out-of-Hospital Birth

Transfer Protocols for Out-of-Hospital Birth

Position Statement

Clinical Information

Policy & Position Statements

Position Statements

December 10, 2025

While the majority of births in the United States take place in a hospital or accredited birth center setting, there are patients who prefer to give birth outside the hospital and who prefer a nonphysician birth attendant. Rates of planned out-of-hospital birth are expected to continue to rise.[1] There has also been an alarming increase in labor and delivery unit closures in recent years, putting access to a nearby delivery hospital out of reach for a growing number of patients. More than 100 rural hospitals closed their labor and delivery units since 2020, impacting the majority of states.[2] Over half of rural hospitals in the United States do not offer labor and delivery services.[3]

ACOG endorses hospitals and community midwives working together to improve transfer (Dec. 2025)

Journal of Midwifery & Women's Health

Commentary

Quality Improvement in Community Birth: A Call to Action

Silke Akerson[1], CPM, MPH, Tanya Khemet Taiwo[2], CPM, LM, PhD, MPH, Melissa A. Denmark[3], CPM, LM, MA
Catherine Collins-Fulea[4], CNM, DNP, Cathy Emeis[4,5], CNM, PhD, Rosanna Davis[1], LM, Rachel A. Pilliod[6], MD

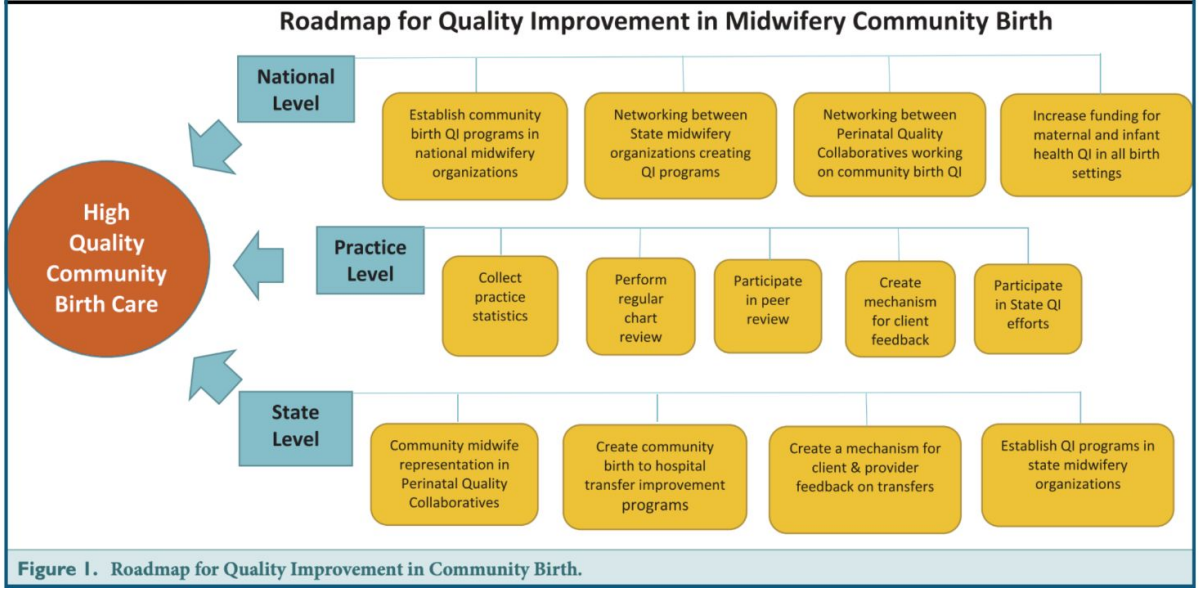


Figure 1. Roadmap for Quality Improvement in Community Birth.

State-Level:
Community midwife representation in perinatal quality collaboratives.

Create community to hospital transfer improvement programs

Create a mechanism for client & provider feedback on transfers

Establish QI programs in state midwifery organizations

NBC NEWS

WOMEN'S HEALTH

When home births go wrong, hospitals can add to the complications

Amid a rise in home births, mistrust between midwives and hospitals can put mothers and babies at risk.

Feb. 26, 2026, 3:30 AM MST

By Aria Bendix

With each contraction, Maria Ibarra's plan to deliver her daughter in her Ohio living room seemed less likely. The baby's heart rate was slowing, her midwife said. They needed to go to the hospital right away.

Ibarra's midwife, Megan Nowland, called labor and delivery at the closest hospital but had trouble reaching anyone. When a charge nurse finally answered, Nowland identified herself as a midwife and asked if the hospital would be able to admit Ibarra, whose baby had a concerning heartbeat

But she was taken aback by the nurse's response.

She was like, 'We just won't take walk-ins,'" Nowland said.

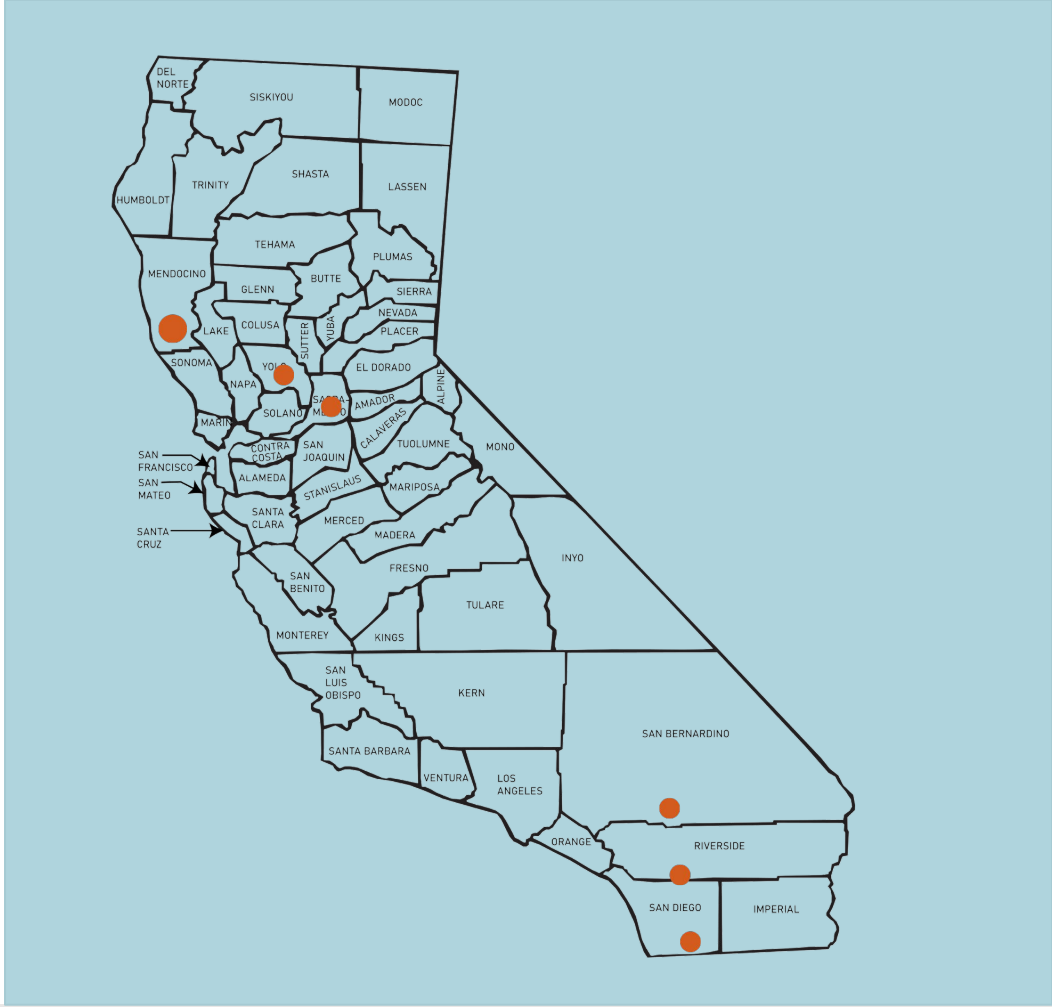
Overview of the Community Birth Transfer Toolkit

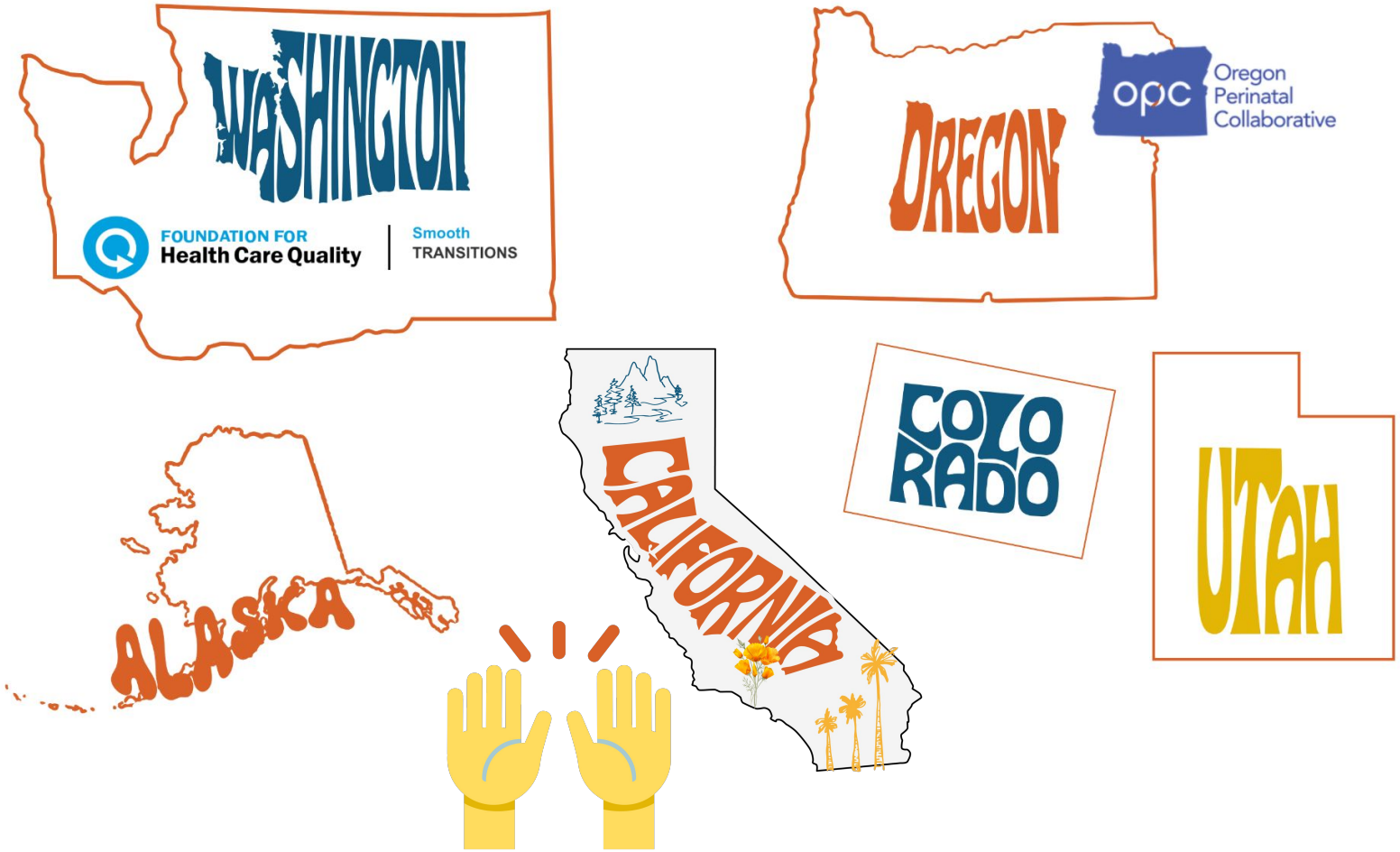
Goals of the CBPI

- Improve relationships and sustained collaboration between community midwives, EMS and hospital birth providers;
- Co-design of policies for hospital transfer by community midwives and hospital providers;
- Ensure safe, coordinated, respectful transfer of care;
- Improve understanding of community birth and reducing stigma around home and birth center births;
- Improve patient experience of transfer;
- Utilize transfer data to improve whole-person safety and quality of care.

Counties of CBPI Pilot Teams

- Mendocino
- Riverside
- Sacramento
- San Bernardino
- San Diego
- Yolo

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COMMUNITY BIRTH TRANSFER RESOURCE KIT

The AIM Community Birth Transfer Resource Kit is a collection of best practices to aid in supporting safe and timely transfers from community birth settings to hospitals if the need for a transfer of care arises. The development of this Resource Kit was supported by a multidisciplinary working group of subject matter experts to foster respect, safety, and communication for patients, families, providers, and systems engaged in community birth transfers.

Download the Full Resource Kit

Components of the CBPI

- Virtual learning opportunities
- Virtual & in-person collaborative work sessions between community midwives, EMS, and hospital staff to co-design policies for transfer
- Virtual and in-person simulations of transfer to practice and improve processes

*Surveys of patient experiences of transfer to integrate patient-focused and community-specific change

Community Birth Partnership Initiative Survey

(Coming soon!)

Project Steps: Smooth Transitions Method

1. Recruit champions from hospital L&D/NICU, EMS, Community Midwives
2. Education & pre-meeting readiness
3. Begin meeting as the *Perinatal Transfer Improvement Committee* with the "Core Triad"
4. Co-design guidelines for maternal/newborn transfer for an intended community birth
5. Continued collaboration: Data collection | Benchmarking | Simulations | Co-Learning
6. Meet quarterly: Utilize experience surveys & debriefs to inform guideline improvements

GET STARTED

Get Started!

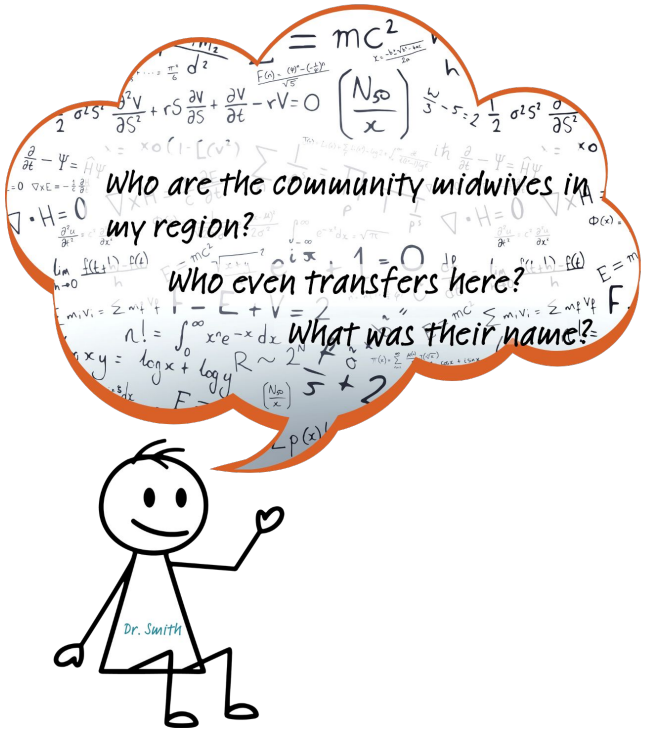
Building a community birth partnership between midwives, EMS, and hospital teams requires a shared commitment to improving outcomes. The success of California's pilot project resulted from teams completing a series of interconnected steps. This guide details those steps, along with supportive resources, in an immediately actionable format.

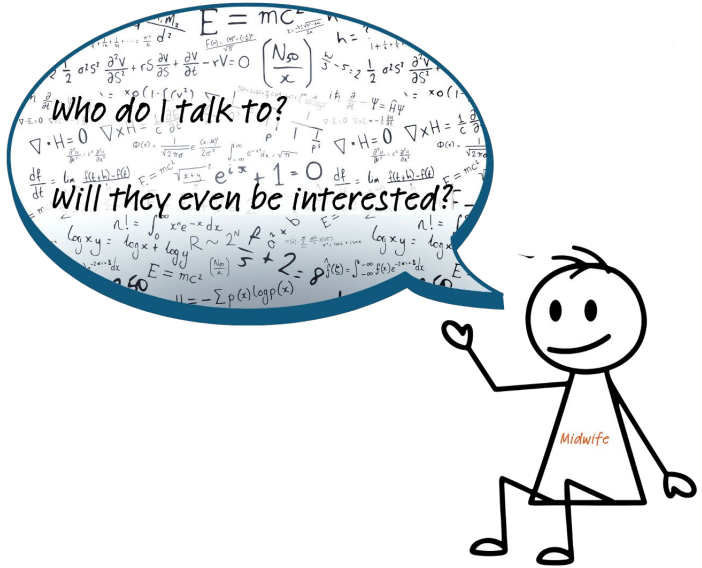
1. Do the Research
2. Assemble the Team
3. Pre-Meeting Education
4. The First Meeting as the "Perinatal Transfer Improvement Committee"
5. Subsequent Meetings
6. Simulations
7. Sustain the Work

Community Birth Transfer Toolkit
CMQCC Quality Improvement Toolkit
Page 14

An immediately actionable guide to improve transfers.

Where do we begin??





FOR HOSPITALS & EMS

1 Do the Research

- Online search with keywords
- Regulatory Listings
- State professional associations' websites: tools like "Find a Midwife"
- Talk to CNMs at your hospital→ they have "midwife friends"

FOR COMMUNITY MIDWIVES

1 Do the Research

State Professional Associations:

- California Association of Licensed Midwives (CALM)
- California Nurse-Midwives Assocation (CNMA)

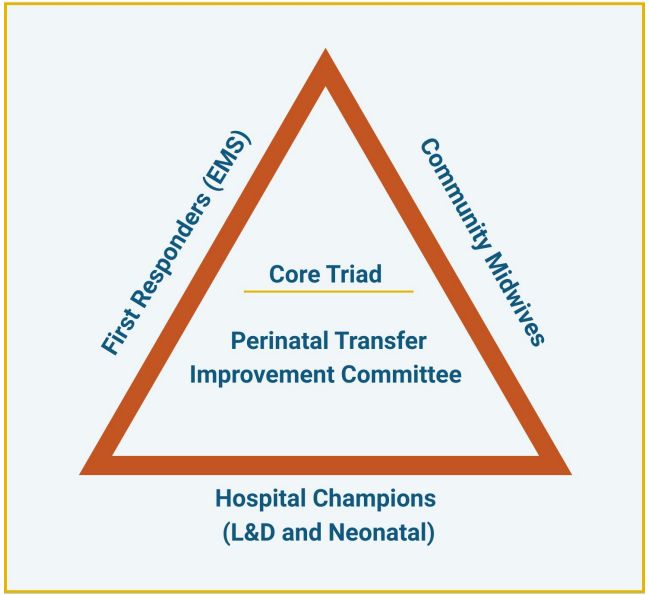
- **National:**
  National Association of Certified Professional Midwives
- American College of Nurse-Midwives

REACH OUT TO THEM!!

2 Assemble the Team

Core Triad for Perinatal Transfer Improvement Committee:

- Community midwives
- Hospital champions (a mix of nurses, nurse managers, perinatal nurse educators, obstetricians or MFMs, NICU staff, pediatricians, neonatologists, nurse-midwives).
- EMS (at minimum a paramedic/EMT from key ambulance providers and/or fire departments if they are first responders for community births in your area. Ideally, this group would also include someone delegated by the Local EMS Administrator–LEMSA–to represent the county).



2 Assemble the Team

- Go to your computer.
- Pull up your email.
- Write an email (a nice one).
- Invite them to be a part of this work.
- Don't say "midwives need better training" or "your hospital is doing a really bad job at transfers" → say something like "we'll do better if we work together."
- Name drop 😉 ("CMQCC really wants us to do this!")
- Acknowledge that you don't have all the answers on how to do this, but getting the right people on board will move you closer to success

Then the Magic Happens

2 Assemble the Team

KEY: Don’t assume that a similar thing isn’t already happening…
Leverage local work to make bigger and better progress!

2 Assemble the Team

Key: Identify the lead hospital champion, lead midwife liaison, and lead EMS champion together.

They act as liaisons for the purposes of meeting facilitation and to spread new information to their respective professional communities

2 Assemble the Team

RESOURCES FOR STEP 2

- Readiness Section, *AIM Community Birth Transfer Resource Kit*
- Template Outreach Email
- Template Roster for Perinatal Transfer Improvement Committee

3 Pre-Meeting Education

- Don’t skip this step
- Do not underestimate the fact that you “don’t know what you don’t know”

3 Pre-Meeting Education

Hospital

Self-Directed Reading

- CMQCC Community Birth Partnership Initiative Webpage
- CMQCC FAQs About Transfer
- CMQCC Midwifery Model & Philosophy of Care
- CMQCC California Midwives Are Essential Maternity Care Providers
- NASEM: Assessing Risk and Benefit by Birth Setting

Self-Directed Viewing

- CE Course: *Transfer Tools for Midwives, EMS, and Hospital Providers*
- Kindred Space LA (YouTube)

Before First Transfer Improvement Meeting with Community Midwives & EMS

Lead hospital champion for this initiative to meet with other hospital champions to:

- Show CMQCC CBPI slide deck and review goals
- Answer questions and address concerns

3 Pre-Meeting Education

EMS

- CMQCC CBPI Slidedeck for EMS
- CMQCC Community Birth Partnership Initiative Webpage
- CMQCC FAQs About Transfer
- CMQCC Midwifery Model & Philosophy of Care
- CMQCC California Midwives Are Essential Maternity Care Providers
- NASEM: Assessing Risk and Benefit by Birth Setting
- CE Course: Transfer Tools for Midwives, EMS, and Hospital Providers
- Kindred Space LA (YouTube)

Community Midwives

- CE Course: *Transfer Tools for Midwives, EMS, and Hospital Providers*

3 Pre-Meeting Education

RESOURCES FOR STEP 3

- CMQCC CBPI Slide Deck
- CMQCC: Community Birth Partnership Initiative Webpage
- CMQCC: California Midwives Are Essential Maternity Care Providers (PDF)
- CMQCC: Frequently Asked Questions About Transfer (PDF)
- CMQCC: Midwifery Model & Philosophy of Care (PDF)
- CMQCC: Midwives in California: Education, Regulation, Scope of Practice
- HIVE CE: Transfer tools for Midwives, EMS, and hospital providers (CE course)
- NASEM: Assessing Risk and Benefit by Birth Setting (PDF)
- YouTube: Kindred Space LA: An Oasis of Black Motherhood and Birth

Who are Community Midwives?

Quick Guide to California Midwives

Community Midwives specialize in the care of essentially healthy (aka low-risk) birthing people & newborns in the out-of-hospital setting by combining the midwifery model of care (patient-centered, community-oriented, low intervention, & emphasizes continuity of the human presence during labor) with medical techniques to safeguard normal birth.

Types of Midwives in California

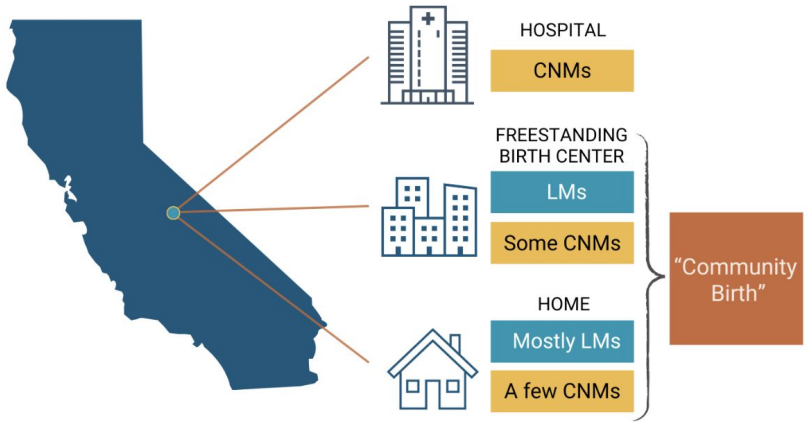
A Quick Guide to California Midwives

There are two types of midwives licensed and certified in California:

Licensed Midwives (LMs)

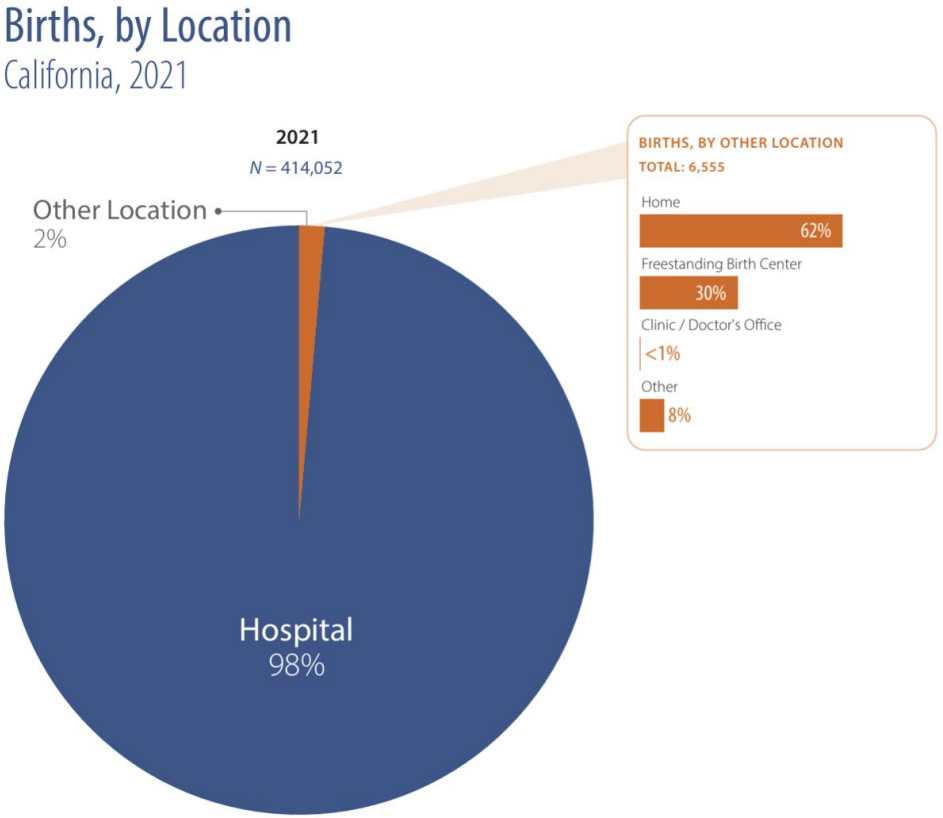
Certified Nurse-Midwives (CNMs)

SITES OF MIDWIFE-ATTENDED BIRTHS IN CALIFORNIA



Certified Nurse-Midwives (CNMs) and Licensed Midwives (LMs) in California are independent maternity and reproductive health care providers who consult, collaborate, and transfer care when indicated

Community Birth In California



- CA has highest number of midwife-attended births in the nation! (but not highest in community birth)
- 55,000 total midwife-attended births in CA and 5,000 of those happen in the community (out-of-hospital)
- 2% of CA births happen in the community setting

Community Birth Transfers/Transports

Transfer from home or birth center to hospital happens in about 11% of community births in the intrapartum or immediate postpartum period.

The **most common reasons overall** for transfer are NOT for emergencies:

- pain relief
- labor augmentation when labor progress is no longer ”normal”

Emergency transfers happen in about 2% cases. In CA, the most common reasons for emergency transfer are:

- Severe postpartum hemorrhage
- Fetal bradycardia

A Typical Community Midwife Patient

(Quick Guide to California Midwives)

- Essentially healthy (no significant pre-pregnancy or pregnancy conditions that are likely to adversely affect the birthing person, fetus, or newborn)
- One fetus in the head down position
- Full-term at the time of labor (37-42 weeks)
- Risk assessment is ongoing (every prenatal visit; during labor)

3 Pre-Meeting Education

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THE MIDWIFERY MODEL OF CARE & PHILOSOPHY

COMMUNITY BIRTH PARTNERSHIP INITIATIVE

What the Midwifery Model of Care Looks Like in Community Settings in California*

- Comprehensive care management and attention to health-related social needs with necessary referrals (e.g., food assistance, housing, intimate partner violence, etc.)
- Trauma-informed care is standard
- Continuous risk assessment with early referral to physician care if medical needs arise; ability to consult with a physician is essential
- Collaboration with doulas and other professionals who can improve wellbeing and enhance care
- Personalized education for nutrition, exercise, lactation, urgent maternal warning signs, and childbirth
- Hour-long prenatal visits
- 24/7 access to a midwife whom the patient is well acquainted with
- Continuous presence during labor and birth
- 3-5 hour-long postpartum visits in the first 6 weeks (the time when most maternal mortality occurs)
- Dyadic care (patient and baby cared for together in postpartum period)
- One-on-one lactation support as needed and for as many visits as needed

*Community midwifery = midwifery care in homes and freestanding birth centers

Philosophy of Midwifery Care *(as defined by the International Confederation of Midwives[1])*

The International Confederation of Midwives' philosophy of midwifery care affirms pregnancy and childbearing as typically normal, physiological experiences that are deeply meaningful to women and their communities. Midwives are ideal providers for low-risk people, offering holistic, continuous, and collaborative care that supports women's health, rights, and self-determination. This respectful, personalized care builds confidence in childbirth, grounded in ethical principles, individuals' backgrounds, and an understanding of women's comprehensive experiences. Competent midwifery is continuously informed by education, scientific research, and evidence.

[1]International Confederation of Midwives. Core Document: Philosophy and Model of Midwifery Care. https://internationalmidwives.org/wp-content/uploads/eng-philosophy-and-model-of-midwifery-care.pdf. Accessed 7/1/25.

Collaboration Is Essential

Studies show that outcomes are better for low-risk, essentially healthy people receiving community-based midwifery care when midwives are part of an integrated healthcare system where they can practice to the top of their training, easily consult with physicians when medical issues arise, and efficiently transfer to physician care and/or higher levels of care as needed, as compared to patient and population outcomes when midwives are not fully integrated into the healthcare system. The Community Birth Partnership Initiative encourages collaboration across care settings and between different provider types (e.g., between physicians and midwives), promoting team-based care to improve outcomes for low-risk individuals giving birth in community settings.

CMQCC
California Maternal Quality Care Collaborative

MIDWIVES IN CALIFORNIA: EDUCATION, REGULATION, SCOPE OF PRACTICE, AND CARE ENVIRONMENTS

COMMUNITY BIRTH PARTNERSHIP INITIATIVE

Types of Midwives in California

- Certified Nurse-Midwives (CNMs)
- Licensed Midwives (LMs)
- Total number of midwives in CA (CNMs and LMs combined) = 1,600

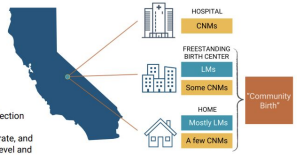
Education and Regulation

CNMs	Nurse-midwifery education program (typically 2-4 years) approved by the Board of Registered Nursing (BRN)	→ American Midwifery Certification Board Exam (AMCB Exam) – confers Certified Nurse-Midwife (CNM) credential	→ CNMs are regulated by the BRN
LMs	A midwifery education program that is at least three years in length and approved by the Medical Board of California (MBC); these programs are referred to as "direct entry" programs, meaning programs that do not require a previous nursing degree	→ North American Registry of Midwives Board Exam (NARM exam) – confers Certified Professional Midwife (CPM) credential (referred to as LMs in California)	→ LMs are regulated by the MBC

Scope of Practice

- Low-risk pregnancy, labor, and birth in hospitals, freestanding birth centers, and homes
- CNMs and LMs care for patients who meet the criteria of "low-risk" as defined by the Board of Registered Nursing and the Medical Board of California, respectively; CNMs and LMs are obligated to transfer-higher risk patients
- Management of "normal" changes of pregnancy, including miscarriage care; medication or aspiration abortion in the 1st trimester (CNMs only)
- Well-newborn care
- Well-person gynecologic care, including sexually transmitted infection (STI) care, contraception, and care during menopause
- CNMs and LMs are independent providers who consult, collaborate, and transfer care when necessary as indicated by the patient's risk level and medical conditions

Environments of Care in California



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MIDWIVES & COMMUNITY BIRTH

COMMUNITY BIRTH PARTNERSHIP INITIATIVE

Frequently Asked Questions About Transfer to the Hospital From a Community Birth

Whom do midwives care for? Midwifery care is appropriate for the majority of women and pregnant people. In the community setting, midwives care for essentially healthy (low-risk) pregnant people and newborns during the normal childbearing period.

How often does community birth transfer happen? On average, 11% of patients transfer from the community birth setting to the hospital.[1]

How is risk evaluated, and when do midwives consider transfer of care? Both CNMs and LMs in California have comprehensive guidance outlining conditions that a midwife may encounter in practice for which discussion, consultation, or transfer of care is indicated. Safe midwifery care relies on expert risk assessment by the midwife to determine who may need a higher level of care and when. During prenatal, birth, postpartum, and well newborn care, risk assessment is ongoing.

Who decides when a patient should transfer? Risk assessment is a key part of midwifery training and practice. Midwives decide when a patient no longer fits within their low-risk scope of practice. Like all licensed healthcare providers, midwives are ethically obligated to educate their clients on everything happening during their prenatal, birth, and postpartum care and engage in shared decision-making with rigorous discussions of the risks and benefits of potential decisions. Additionally, midwives in California are required to have a written transfer plan, which is shared in advance with the client. This transfer plan includes conditions or situations that require transfer to a higher level of care, ensuring the client and family are educated ahead of time on the situations that may occur.

What are the most common reasons for transfer to the hospital during labor? The most common reasons are for pain relief and prolonged labor. Emergency transfers (by ambulance) occur only for about 2% of patients who intend to birth in their home or a freestanding birth center.[2]

1. Cheyney M, et al. Outcomes of Care for 16,924 Planned Home Births in the United States. *J Midwifery Womens Health*. 2014;59(1):17-27. 2. Boyberg ML, et al. Planned Home Births in the United States Have Outcomes Comparable to Planned Birth Center Births for Low-Risk Birthing Individuals. *Med Care*. 2024;62(12):820-826.

AIM

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

COMMUNITY BIRTH TRANSFER RESOURCE KIT

The AIM Community Birth Transfer Resource Kit is a collection of best practices to aid in supporting safe and timely transfers from community birth settings to hospitals if the need for a transfer of care arises. The development of this Resource Kit was supported by a multidisciplinary working group of subject matter experts to foster respect, safety, and communication for patients, families, providers, and systems engaged in community birth transfers.

Download the Full Resource Kit

4 The First Meeting as the "Perinatal Transfer Improvement Committee"

Designated leads should meet **before** the first full committee meeting to review the agenda and determine who will lead or participate in each portion of the discussion.

The designated lead(s) coordinate meetings, document discussions, and follow up on outstanding tasks.

The First Mtg Focuses On:

- Introductions and building rapport.
- Framing the initiative and reviewing goals.
- Reviewing meeting communication rules.
- Reviewing the meeting cadence.
- Answering any questions or concerns.
- Participants may want to review priority issues.

4 The First Meeting as the "Perinatal Transfer Improvement Committee"

RESOURCES FOR STEP 4

Meeting Templates

- Agenda for First Meeting
- Follow-up Email
- Conversation Ground Rules
- First Meeting Slidedeck

Template Transfer Guideline
(adapted from Smooth Transitions)

Ice Breakers (YouTube)

- "My first job"
- 2-minute No-Prep Ice Breakers

Best Practices

- Best Practice Guidelines: Transfer from Planned Home Birth to Hospital
- Best Practices for Interprofessional Collaboration: Community Midwives and Specialist Providers

5 Subsequent Meetings

- Follow-up meetings should be scheduled monthly for the next three to four months.
- This cadence provides time to discuss and finalize guidelines for antepartum, intrapartum, newborn, and postpartum transfers.
- After that period, the team may transition to quarterly meetings to maintain open communication and sustain the goals achieved during the active phase of the project. If that is not possible, teams should meet twice per year (at a minimum).

5 Subsequent Meetings

Transfer improvement meetings are not protected case reviews. The committee should identify strengths and gaps using insights gleaned from transfer experience surveys and hypothetical scenarios. If a specific case requires intense review to glean additional information to inform improvement, it should be referred through the usual case review channels.

RESOURCES FOR STEP 5

Best Practices

- Best Practice Guidelines: Transfer from Planned Home Birth to Hospital
- Tips for Welcoming a Transfer (Oregon Community Birth Transfer Partnership)

Debriefing – Model Forms & Guides

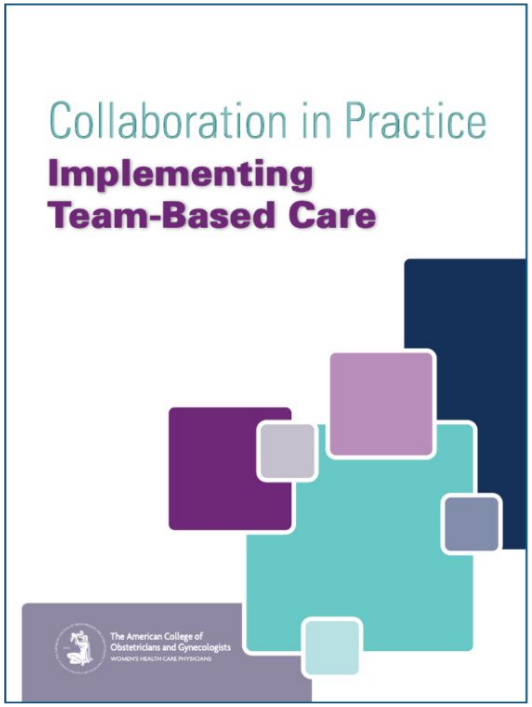
CMQCC Debrief Form
UWNQC 3-Question Debrief Form
W3 Method for Debriefing

Transfer Templates

- Birth Place Lab Model Maternal and Newborn Transfer Forms
- CMQCC Transfer Form (adapted from California Birth Center)
- SBAR for Community Midwife (IHI)
- SBAR Script for Receiving Facility (Smooth Transitions)

Respectful Maternity Care as the Foundation for Transfer Partnerships

When hospital teams and community midwives come together, many concerns surface—but the conversation repeatedly returns to one shared commitment: respectful, patient-centered care.



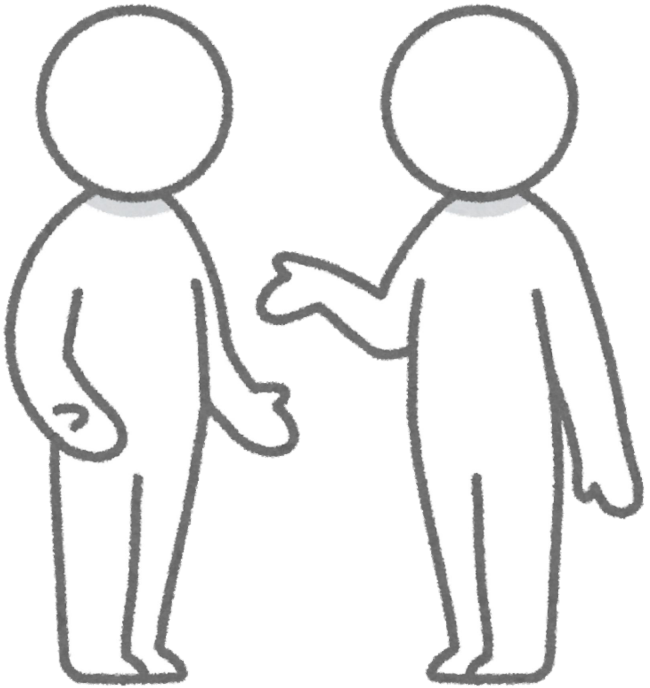
First Guiding Principle of Team-Based Care = Center the Patient

Guiding Principles

1. Patients and families are central to and actively engaged as members of the health care team.
2. The team has a shared vision.
3. Role clarity is essential to optimal team building and team functioning.
4. All team members are accountable for their own practice and to the team.
5. Effective communication is key to quality teams.
6. Team leadership is situational and dynamic.

Values Framing for CBPI

- Every provider brings their own experiences and perspectives to patient care.
- During the CBPI in-person meetings we break this down in what we call ***“the values talk”.***



The Values Talk: Mini Version

VALUES = The beliefs, priorities, and principles that guide what matters most to a person and influence the choices they make.

Our beliefs & values are created by, informed by, and protected by:

- Family or chosen family (our "tribes")
- Experiences
- Trauma
- Culture and traditions
- Social norms and expectations
- Professional environment and professional expectations
- Religion or faith Tradition
- Educational background
- Mentors / Elders

RESULT: It's like a sweater, each concept connecting to the next. If you start to pull on one, the fabric risks completely unraveling. Our brains treat "change" to this system as a threat.

Experience Examples

Values and beliefs for community birth providers, hospital providers, and EMS are be shaped by:

- Concerns about safety in different birth settings
- Prior experiences with difficult transfers
- An actual bad outcome that was transfer-related
- Differences in training, culture, and workflow
- Stories that have shaped perceptions of risk

*These perspectives are real, and they deserve space to be acknowledged.

The Values/Beliefs Behind the Choice of Where to Give Birth

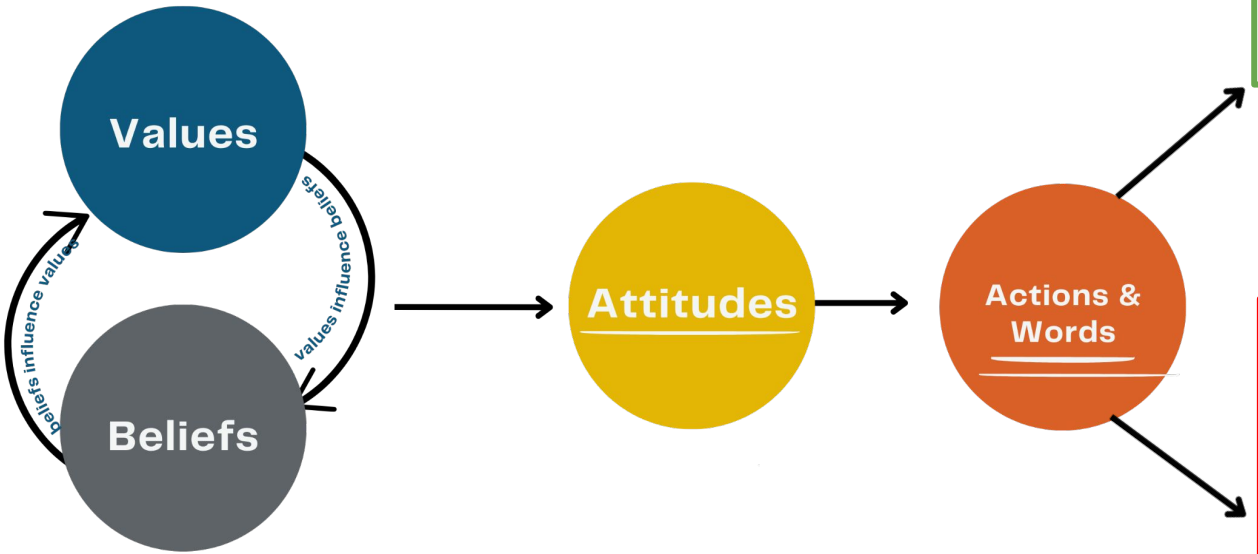
Community

- Autonomy and ability to question tests/procedures
- Feels emotionally safer and physically safer
- Feeling of being more informed
- Fewer interventions
- Feeling understood and affirmed in their beliefs
- For a more profound experience
- Control over their bodies
- The relationship with their midwife & continuity
- A family-centered environment
- Being in their own space
- Longer visits and a direct access to their provider when they need them
- Their religious or cultural beliefs

Hospital

- Safety and emergency Care: Immediate access to OB-GYNs, anesthesiologists, and neonatal specialists if complications arise
- Full range of pain management options
- Continuous fetal monitoring
- Immediate NICU access
- Insurance coverage
- Physician care / high-risk management
- Their partner's preference or their family's preference
- Feels safer; wanting to keep baby "as safe as possible"

Our Attitudes (and Actions/Words) Can Be *Negatively* Impacted By Our Values and Beliefs

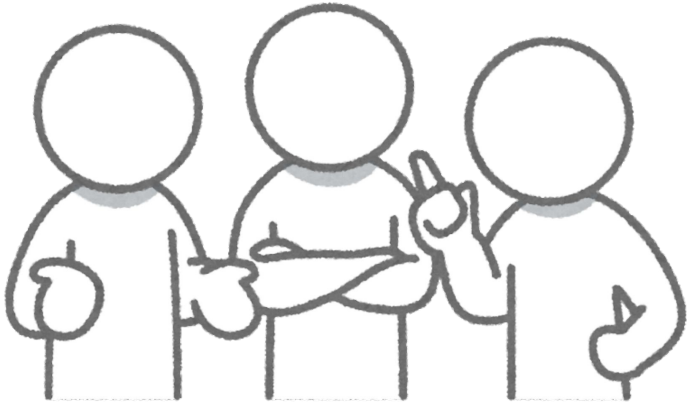


"We're glad you're here with us and I'm so sorry things didn't work out how you planned."

"Why would you want a home birth? I promise you'll be much more comfortable here!"

Core Values & Beliefs Are Not Easily Changed

- Solidified over time with repeated exposure and (sometimes) via confirmation bias.
- Are often connected to entangled with concepts of “good vs bad”.
- Paired with deeply embedded emotional responses when we see something that contradicts these beliefs – like a homebirth, or a hospital birth (depending on the person).



It takes a pretty significant event to change our beliefs or alter our values.

Luckily, we don't have to.

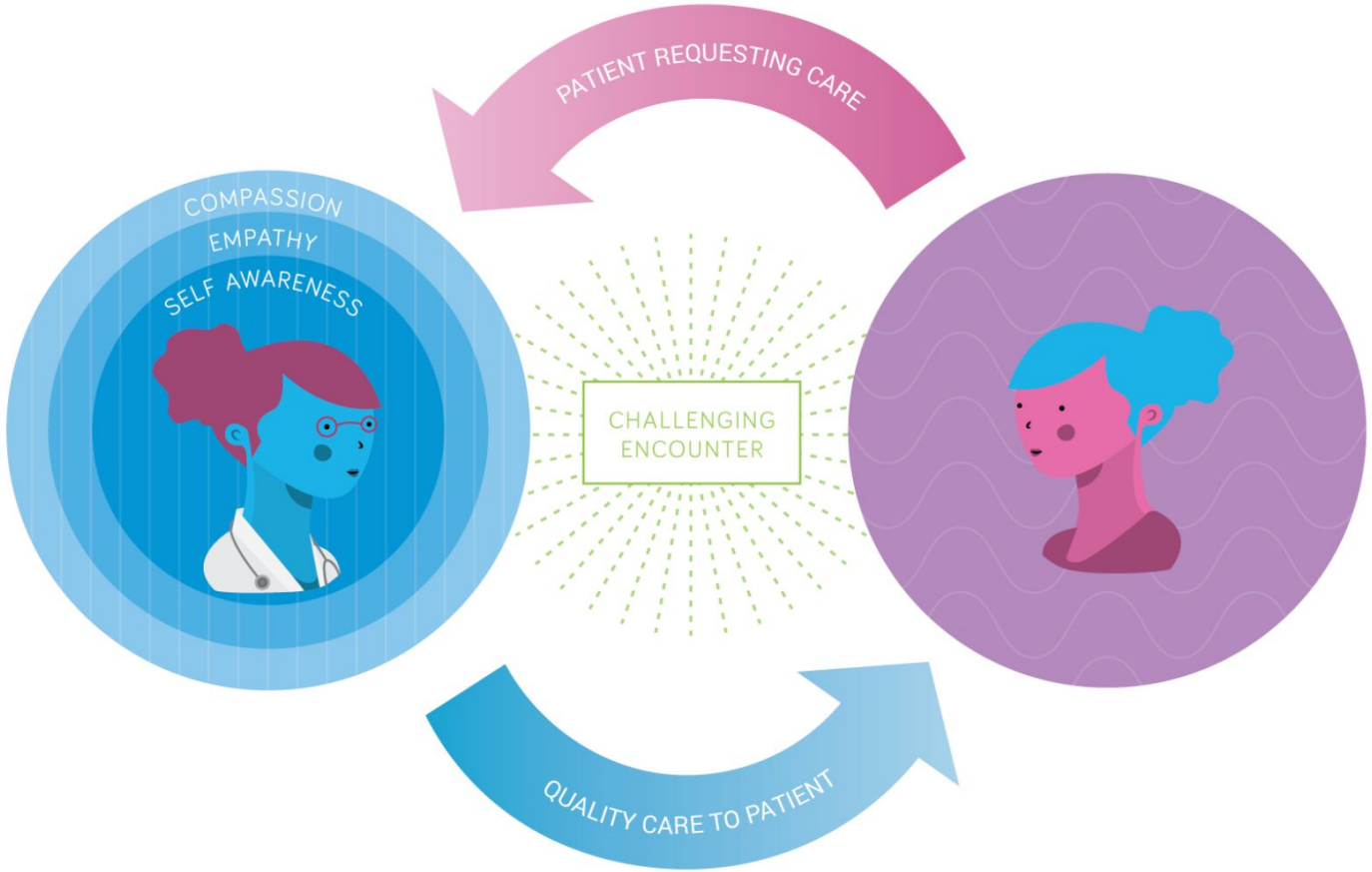


Image credit: Bixby Center for Global Reproductive Health

What Respectful Care Looks Like During Transfer

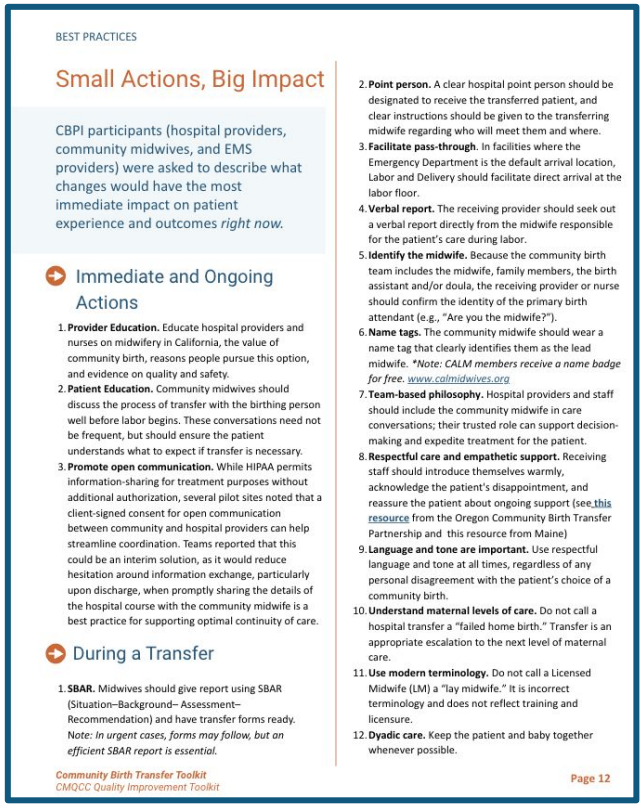
Community

- Share clear clinical information
- Respect hospital processes and protocols
- Support the patient during the transition of care
- Use professional language to engage with the nurses and providers in order to expedite treatment for your client

Hospital

- Listening to the patient's preferences and concerns
- Acknowledge that this isn't what they wanted for their birth
- Welcome the community midwife's clinical report & invite them into the patient conversation
- Communicate openly and professionally

Small Actions, Big Impact



BEST PRACTICES

Small Actions, Big Impact

CBPI participants (hospital providers, community midwives, and EMS providers) were asked to describe what changes would have the most immediate impact on patient experience and outcomes *right now.*

Immediate and Ongoing Actions

1. **Provider Education.** Educate hospital providers and nurses on midwifery in California, the value of community birth, reasons people pursue this option, and evidence on quality and safety.
2. **Patient Education.** Community midwives should discuss the process of transfer with the birthing person well before labor begins. These conversations need not be frequent, but should ensure the patient understands what to expect if transfer is necessary.
3. **Promote open communication.** While HIPAA permits information-sharing for treatment purposes without additional authorization, several pilot sites noted that a client-signed consent for open communication between community and hospital providers can help streamline coordination. Teams reported that this could be an interim solution, as it would reduce hesitation around information exchange, particularly upon discharge, when promptly sharing the details of the hospital course with the community midwife is a best practice for supporting optimal continuity of care.

During a Transfer

1. **SBAR.** Midwives should give report using SBAR (Situation–Background– Assessment–Recommendation) and have transfer forms ready. *Note: In urgent cases, forms may follow, but an efficient SBAR report is essential.*
2. **Point person.** A clear hospital point person should be designated to receive the transferred patient, and clear instructions should be given to the transferring midwife regarding who will meet them and where.
3. **Facilitate pass-through**. In facilities where the Emergency Department is the default arrival location, Labor and Delivery should facilitate direct arrival at the labor floor.
4. **Verbal report.** The receiving provider should seek out a verbal report directly from the midwife responsible for the patient's care during labor.
5. **Identify the midwife.** Because the community birth team includes the midwife, family members, the birth assistant and/or doula, the receiving provider or nurse should confirm the identity of the primary birth attendant (e.g., "Are you the midwife?").
6. **Name tags.** The community midwife should wear a name tag that clearly identifies them as the lead midwife. **Note: CALM members receive a name badge for free. www.calmidwives.org*
7. **Team-based philosophy.** Hospital providers and staff should include the community midwife in care conversations; their trusted role can support decision-making and expedite treatment for the patient.
8. **Respectful care and empathetic support.** Receiving staff should introduce themselves warmly, acknowledge the patient's disappointment, and reassure the patient about ongoing support (see this resource from the Oregon Community Birth Transfer Partnership and this resource from Maine)
9. **Language and tone are important.** Use respectful language and tone at all times, regardless of any personal disagreement with the patient's choice of a community birth.
10. **Understand maternal levels of care.** Do not call a hospital transfer a "failed home birth." Transfer is an appropriate escalation to the next level of maternal care.
11. **Use modern terminology.** Do not call a Licensed Midwife (LM) a "lay midwife." It is incorrect terminology and does not reflect training and licensure.
12. **Dyadic care.** Keep the patient and baby together whenever possible.

BEST PRACTICES

Small Actions, Big Impact

After Transfer

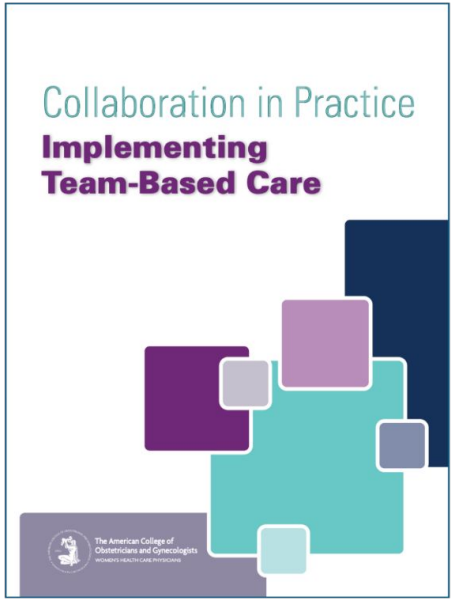
1. **Immediate debrief.** Whenever possible, the hospital provider, nurse, community midwife, and EMS should have an immediate debrief. If not, the hospital provider should attempt to schedule within one week (virtual or in-person).
2. **Continuity of care and patient records.** Upon discharge, the hospital care team should promptly share details of the hospital course and postpartum follow-up plans with the community midwife. If no such system exists, establish a standardized process and communicate it to all parties.

For First Responders

1. **Education on Community Birth.** Educate EMS personnel on midwifery and community birth in California, particularly in their region.
2. **Scene size-up for planned community birth.** For community birth transfers, assume that the plan is to "load and go" as quickly as possible (but confirm upon arrival). For efficiency, ask the following questions:
   - "Who is the midwife?" (don't assume)
   - "Has the patient already given birth?" If birth has already occurred, ask "who needs transport? Mom, baby, or both?"
   - "Is this a 'load-and-go' situation?" (proceed accordingly)
3. **Avoid unnecessary delay.** Avoid repeat assessments already performed by the midwife.
4. **Facilitate pass-through**. In facilities where the Emergency Department is the default arrival location, EMS should facilitate rapid pass-through to the labor floor.
5. **Team-based philosophy.** Recognize that this situation differs from an unplanned out-of-hospital birth. A licensed provider with obstetric training and emergency experience is present; coordinate care as a team.
6. **Allow the midwife to accompany the patient during ambulance transport when feasible** to maintain continuity of care and facilitate clinical handoff.
7. **Continuation of emergency care.** Do not interrupt or discontinue emergency obstetric interventions being performed by the midwife during transfer. For example, do not discontinue oxytocin administration, do not halt bimanual uterine compression during a postpartum hemorrhage, or halt a vaginal examination for cord prolapse.
8. **Maternal positioning can be a critical treatment in obstetric emergencies.** Follow the midwife's guidance on maternal positioning during transport (e.g., lateral or hands-and-knees for fetal compromise; hips elevated for cord prolapse).
9. **Newborn resuscitation is not the same as infant resuscitation.** Community midwives are well-trained in newborn resuscitation in homes and birth centers. It is encouraged that the on-scene midwife take primary responsibility for newborn resuscitation, with the support and collaboration of EMS.
10. **Immediate debrief.** Whenever possible, the hospital provider, nurse, community midwife, and EMS should immediately debrief. If they wish, EMS can leave their contact information with the midwife and request a debrief phone call.

Toolkit Pages 12 & 13:

List of concepts anyone can apply immediately to improve transfer & respectful care (from CBPI pilot teams).



2nd Guiding Principle of Team-Based Care = Team has a shared vision

Guiding Principles

1. Patients and families are central to and actively engaged as members of the health care team.
2. The team has a shared vision.
3. Role clarity is essential to optimal team building and team functioning.
4. All team members are accountable for their own practice and to the team.
5. Effective communication is key to quality teams.
6. Team leadership is situational and dynamic.

When respectful care is the shared vision for the team:

- Conversations become more collaborative & communication improves
- Efficiency improves
- Transfers become less adversarial
- The birthing person experiences greater dignity and support → improved outcomes overall

6 Simulations

Enhances Respectful Client-Centered Care

Teams can rehearse using clear, compassionate communication and shared decision-making during transfers, helping clients feel informed and supported even in stressful circumstances

Team-Building & Trust

Practicing together helps midwives, nurses, physicians, and EMS understand each other's roles and develop confidence in one another before a real emergency occurs.

These interactions build a foundation of trust that cannot be achieved through virtual meetings and written protocols alone.

Identifies System Gaps

Simulations often reveal unclear responsibilities, missing protocols, or delays in communication that would not be obvious on paper.

Improves Response Times

Repeated practice helps teams coordinate more efficiently in urgent situations, reducing time to needed interventions.

Creates a Culture of Learning

Debriefing after a drill allows everyone—community providers, hospital staff, and EMS—to share perspectives, identify strengths, and co-develop solutions.

6 Simulations

RESOURCES FOR STEP 6

- DEBRIEFING AFTER DRILLS & SIMULATIONS (AIM)
- DRILL KITS (STEP UP TOGETHER)
- BEST PRACTICES FOR HANDOFF COMMUNICATION (MAINE CDC)

7 Sustain the Work

- ☑ Quarterly or semiannual meetings of the Perinatal Transfer Improvement Committee.
- ☑ A written sustainability plan completed by the Perinatal Transfer Improvement Committee, ideally just before meetings transition to a quarterly/semiannual schedule.
- ☑ Transfer experience surveys with a clear plan for distribution to patients and families and applied to inform improvements.
- ☑ New employee orientation materials that are built into the standard onboarding process.
- ☑ Regular benchmarking/reporting of transfer data to the Perinatal Transfer Improvement Committee—annually at minimum.
- ☑ An annual full review of the transfer guidelines, followed by every 2-3 years once established.
- ☑ High-fidelity simulations conducted at least once per year to maintain skills, relationships, and readiness.
- ☑ Continued team-building activities.

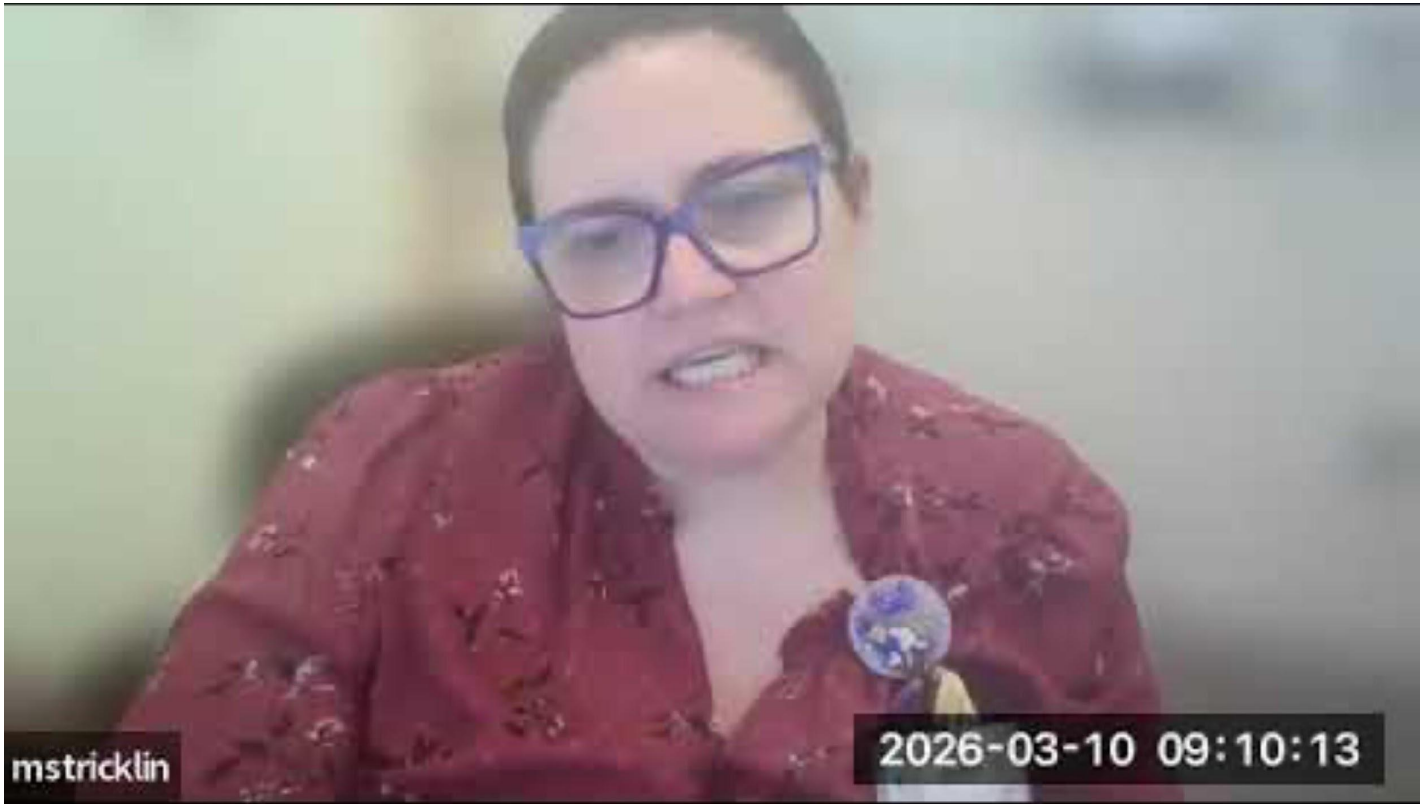
7 Sustain the Work

RESOURCES FOR STEP 7

- Annual Audit Form (Oregon Community Birth Transfer Partnership)
- CMQCC Structure Measures
- Drill Kits (Step Up Together)
- Midwife Introduction Form (adapted from UNWPQC)
- New Employee Packet
- Sustainability Plan
- Team-Building Activities
- Transfer Experience Surveys

Rachel's Story

Melaney's Story



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