Community Birth Transfer Toolkit

A CMQCC Quality Improvement Toolkit

CMQCC

COMMUNITY BIRTH
PARTNERSHIP INITIATIVE

March 2026

CMQCC
California Maternal
Quality Care Collaborative

Community Birth Transfer Toolkit

A Quality Improvement Toolkit

This toolkit references publicly available tools from various community birth transfer improvement initiatives. External sources are credited.

This toolkit is considered a resource but does not define the standard of care in California. 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 not to rely solely on the guidelines presented here.

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Notes on Terminology

The terms “mother,” “maternal,” “she,” or “her” refer to a person who is pregnant or has given birth. We recognize that not all people who become pregnant and give birth identify as mothers or women. We believe all persons are equally deserving of patient-centered care that helps them attain their full potential and live authentic, healthy lives. The term “family” refers to any persons the pregnant or postpartum patient designates as such (alternatives: partners, husbands, wives, support persons, loved ones).

Conflict of Interest

The contributing authors have no affiliations or financial interests that conflict with the material or recommendations presented in this Toolkit.

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We extend our sincere gratitude to the organizations listed below for their invaluable contributions. Through years of collaborative work between hospitals and community midwives, they have developed essential tools and influential concepts that have significantly advanced community birth transfer practices. Organizations are presented in alphabetical order below (click below to view).

We particularly acknowledge the flagship work of Smooth Transitions in Washington and the efforts of the Oregon Perinatal Collaborative.

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Alaska Birth Transfer Initiative (a project of the Alaska Perinatal Collaborative)

Alliance for Innovation on Maternal Health (AIM)

Birth Place Lab

California Association of Licensed Midwives (CALM)

California Nurse-Midwives Association (CNMA)

Colorado Safe Transfers Coalition

Midwives' Association of Washington State (MAWS)

Oregon Community Birth Transfer Partnership (a project of the Oregon Perinatal Collaborative)

Smooth Transitions (a project of the Foundation for Health Care Quality)

Step Up Together (a project of Primary Maternity Care)

Uplift Lab

Utah Women's & Newborn Quality Collaborative (UWNQC)

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How to Use this Guide

This guide is a curated, actionable guide for improving community birth transfers. All external resources are credited, with links to original sources for further reference. It is designed for immediate use by hospitals, community midwives, and emergency medical services (EMS) personnel.

Key Resources

AIM Community Birth Transfer Resource Kit

Birth Place Lab

- *Best Practice Guidelines for Interprofessional Collaboration*
- *Best Practice Guidelines: Transfer from Planned Home Birth to Hospital*
- *Model Transfer Forms*

Maine Center for Disease Control and Prevention

- Best Practice Recommendations for Handoff Communication During Transport from a Home or Freestanding Birth Center To a Hospital Setting

National Academy of Science and Engineering

- *Birth Settings in America: Outcomes, Quality, Access, and Choice*

Oregon Community Birth Transfer Partnership

- *Transfer Improvement Toolkit*

Primary Maternity Care

- *Hospital Guide to Integrating the Freestanding Birth Center Model*
- *A Birth Center Primer for Hospital Leaders*

Smooth Transitions

- Resources

Step Up Together

- Drill Kits

Utah Women's & Newborn Quality Collaborative

- Out-of-Hospital Births webpage

CMQCC

COMMUNITY BIRTH PARTNERSHIP INITIATIVE

Introduction

The mission of CMQCC is to end preventable morbidity, mortality and racial disparities in California maternity care. CMQCC uses research, quality improvement toolkits, statewide outreach collaboratives, and its innovative Maternal Data Center to improve health outcomes for birthing people and newborns. This mission does not stop at the hospital doors. California's maternity care system includes a diverse range of birth settings, providers, and communities.

The Community Birth Partnership Initiative (CBPI) brings together midwives, hospitals, and Emergency Medical Services (EMS) to improve safe, respectful, and collaborative transfers from planned community birth settings to hospitals. This guide provides lessons learned and guidance to support effective, equitable care.

California has long been hailed as a leader in maternal health efforts. Despite this, serious challenges remain—lingering mortality rates, entrenched racial disparities, and patchy care access. Midwives are a vital part of California's maternity workforce and are essential to maintaining access, particularly in underserved and rural communities. Together, these circumstances present a significant opportunity to strengthen coordination across the continuum of care—from community to hospital—when a transfer is needed. Nationally, there is a growing call to develop reliable systems that support seamless transfers between community and hospital care.[1-4]

Equity in Community Birth Transfer & Respectful Care for All

Community birth is growing nationwide, with the greatest increase among Black birthing people and people of color.[5,6] However, both hospital clinicians' and community midwives' perceptions of birth in the opposite setting are often shaped by training, professional culture, incomplete data, and experiences during high-intensity events. This limited exposure can reinforce bias and obscure the reality that most care in both environments unfolds without incident and with a deep commitment to person-centeredness.

CBPI emphasizes equity and whole-person care—care that attends not only to clinical needs, but also to a person's values, preferences, cultural context, and lived experience. This philosophy affirms that individuals are entitled to choose the birth setting that best aligns with their needs and priorities. In the context of community birth transfers, this requires approaching families with respect and partnership, honoring informed decisions even when they differ from hospital norms, and ensuring safe and dignified care for all.

Demonstrated Success

Washington was the first state to officially adopt a program to improve transfers. Launched in 2009, **Smooth Transitions** was designed to strengthen communication and foster collaboration between community midwives and hospital-based clinicians. Other western states, including Oregon, Utah, and Alaska, followed suit with similar initiatives. These efforts have contributed to publicly available tools, shared resources, and lessons learned. Experts from these states collaborated with the Alliance for Innovation on Maternal Health (AIM) to create the ***AIM Community Birth Transfer Resource Kit,*** a key resource for best practices and implementation guidance for improving transfer processes.

Legal and Regulatory Context for Community Birth

Legal and regulatory frameworks—and shared responsibility for patient safety—shape community–hospital transfer processes. In California, Licensed Midwives (LMs) attend the vast majority of community births. Certified Nurse-Midwives (CNMs) attend a small portion of community births.[7]

Required Transfer Planning in Community Birth Care. Under California law,[8] LMs and CNMs providing care to people who intend to give birth in the community setting are required to:

- Maintain a written plan for consultation, referral, and transfer of care.
- Provide that plan to clients in both written and oral form.

Professional Implication: These requirements are designed to ensure that clients understand how escalation of care will occur if needed and assurance that midwives proactively plan for collaboration with hospital-based providers.Hospitals can expect that clients arriving from an intended community birth have received counseling about the possibility of transfer and the general process involved. Additionally, they have received extensive information on the risks and benefits of community-based care, as well as those of hospital-based care.

Physician Communication Requirement for Licensed Midwives. California law[9] requires an LM to communicate with the receiving physician. Of note, the law does not require this interaction to be face-to-face and does not specify that it needs to occur at the moment of transfer. Nonetheless, this requirement establishes a formal handoff expectation.

Professional Implication: Transfer policies between hospitals and community midwives should reinforce the importance of real-time clinical communication to support continuity of care. Facilities may still implement policies that support midwife-to-midwife handoff where possible.

Licensure Pathways. LMs are regulated by the Medical Board of California. CNMs are regulated by the Board of Registered Nursing. In California, LMs and CNMs[10]:

- Complete formal midwifery education from an accredited midwifery education program.
- Carry national certification.
- Are required to complete ongoing continuing education.
- Adhere to California's scope of practice rules regulated by their respective regulatory boards.

Professional Implication: In the context of hospital transfer from community birth, community midwives practice within a clear scope of practice, and California maintains high training and licensure standards. Differences between hospital-based and community-based practice reflect structural variations in care settings, not differences in professional rigor or hierarchy of training.

Vicarious Liability: Clarifying a Common Concern. Some hospital providers express concern that establishing transfer relationships with community midwives increases institutional and personal liability exposure. Available evidence and legal analyses suggest[11-13]:

- Accepting a transfer does not create supervisory responsibility for care provided prior to hospital admission.
- Collaboration and structured transfer processes are associated with clearer documentation and safer transitions, both of which are historically correlated with reduced liability risk.

Professional Implication: Policies that formalize respectful communication, defined roles, and standardized handoffs are risk-mitigation strategies, not mechanisms that increase liability.

Midwives in California

- Certified Nurse-Midwives (CNMs)
- Licensed Midwives (LMs)
- Total number of midwives in CA (CNMs and LMs combined) = 1600

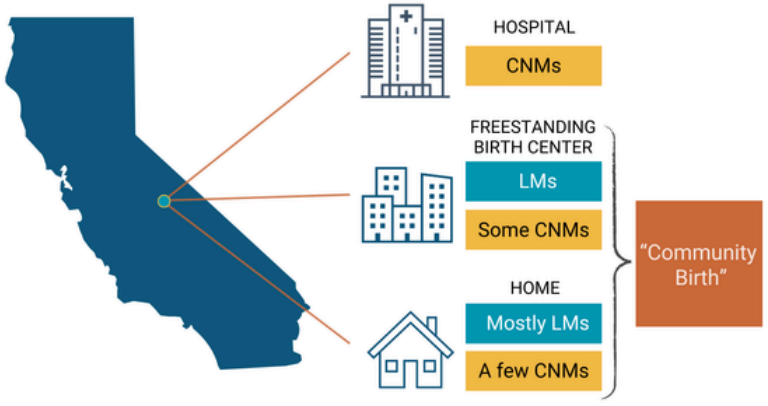
Education and Regulation

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 Board of Registered Nursing
LMs	Direct-entry midwifery education program that is at least 3 years in length & approved by the Medical Board of California (MBC)	→ 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 Medical Board of California

Scope of Practice

- Normal pregnancy, labor, and birth in hospitals, freestanding birth centers, and homes
- 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 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



Best Practices

Multidisciplinary teams participating in two national Home Birth Consensus Summits identified key elements for creating and implementing transfer protocols across birth settings. For more than a decade, these elements have served as a key framework and minimum criteria for improving community birth transfer. They are highlighted prominently in the ***AIM Community Birth Transfer Resource Kit.*** The following guidance is quoted directly from the ***Home Birth Summit Best Practice Guidelines: Transfer from Planned Home Birth to Hospital.***

Model Practices for the Midwife Attending Births at Home or in a Freestanding Birth Center

- In the prenatal period, the midwife provides information to the woman about hospital care and procedures that may be necessary, and documents that a plan has been developed for hospital transfer should the need arise.
- The midwife assesses the status of the woman, fetus, and newborn throughout the maternity care cycle to determine if a transfer will be necessary.
- The midwife will provide notification to the receiving provider or hospital of the incoming transfer, reason for transfer, brief relevant clinical history, planned mode of transport, and expected time of arrival
- The midwife continues to provide routine or urgent care en route in coordination with any emergency services personnel and addresses the psychosocial needs of the woman during the change of birth setting.
- Upon arrival at the hospital, the midwife provides a verbal report, including details on current health status and need for urgent care. The midwife also provides a legible copy of relevant prenatal and labor medical records.
- The midwife may continue in a primary role as appropriate to her scope of practice and privileges at the hospital. Otherwise, the midwife transfers clinical responsibility to the hospital provider.
- The midwife promotes good communication by ensuring that the woman understands the hospital provider's plan of care and the hospital provider understands the patient's need for information regarding care options.
- If the woman chooses, the midwife may remain to provide support and continuity of care.

Model Practices for the Hospital Provider and Staff

- Hospital providers and staff are sensitive to the psychosocial needs of the woman that result from the change of birth setting.
- Hospital providers and staff communicate directly with the midwife to obtain clinical information in addition to the information provided by the woman.
- Timely access to maternity and newborn care providers may be best accomplished by direct admission to the labor and delivery or pediatric unit.
- Whenever possible, the woman and the newborn are kept together during the transfer and after admission to the hospital.
- Hospital providers and staff participate in a shared decision-making process with the woman to create an ongoing plan of care that incorporates the values, beliefs, and preferences of the woman.
- If the woman chooses, hospital personnel will accommodate the presence of the midwife as well as the designated primary support person during assessments and procedures.
- The hospital provider and the midwife coordinate follow-up care for the woman and newborn, and care may revert to the midwife upon discharge.
- Relevant medical records, such as a discharge summary, are sent to the referring midwife.

Best Practices

Quality Improvement and Policy Development

The below is quoted directly from the ***Home Birth Summit Best Practice Guidelines: Transfer from Planned Home Birth to Hospital***.

All stakeholders involved in the transfer and/or transport process, including midwives based at home or in the hospital, obstetricians, pediatricians, family medicine physicians, nurses, emergency medical services personnel, and home birth consumer representatives, should participate in the policy development process. Policies and quality improvement processes should incorporate the model practices above and delineate at a minimum the following

- Communication channels and information needed to alert the hospital to an incoming transfer.
- Provision for the notification and assembly of staff rapidly in case of emergency transfer.
- Opportunities to debrief the case with providers and with the birthing person prior to hospital discharge.
- Documentation of the birthing person's perspective regarding her care during transfer.
- A defined process to regularly review transfers that includes all stakeholders with a shared goal of quality improvement and safety. This process should be protected without risk of discovery.
- Opportunities for education regarding home birth practice, shared continuing medical education, and relationship building that are incorporated into medical, midwifery, and nursing education programs. Multi-disciplinary sessions to address system issues may enhance relationship building and the work culture.

Home Birth Summit

CLICK HERE

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 form** ready. N*ote: 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 communication resource** from the Oregon Community Birth Transfer Partnership **and this resource from Maine CDC)**.
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.

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). See **debrief form here**.
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. **EMS education.** Educate EMS personnel on midwifery and community birth in California, particularly in their region.
2. **Scene size-up for planned community birth.** Assume that the plan is to "load and go" as quicklyf 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.** The midwife has likely already obtained recent vitals and has other assessment data that can be leveraged. Whenever possible, save time by avoiding 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. If 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. **Immediate debrief.** Whenever possible, the hospital provider, nurse, community midwife, and EMS should immediately debrief. If they desire, EMS can leave their contact information with the midwife and ask for a debrief phone call.

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

1 Do the Research

For Hospital and/or EMS Providers: Research the Community Birth Ecosystem in Your Area

Online search. Begin with a simple online search for *home birth midwives in [your city]* or "*freestanding birth centers near me."* Other useful keywords include *licensed midwives*, LMs, CNMs, *midwifery care in [city]*, or *freestanding birth center [city]*.

Regulatory Listings. The most comprehensive tool for finding community birth midwives in your local area is via the Department of Consumer Affairs' (DCA) website. DCA provides a **searchable directory** of all licensees under various professional boards in California.

- Once on the directory page, scroll to and click "Advanced Search."
- On the **Advanced Search page,** select "Medical Board of California" in the "Board or Bureau" drop-down tool.
- Select "Licensed Midwife" in the "License Type" drop-down tool
- Use the city and county drop-down tools to further filter by location (note: you can cast a broader net by simply choosing your county, or be more selective by clicking your city or multiple cities).
- Select "Active" in the "Primary Status" drop-down tool.
- Finally, click "search" to create a list of active Licensed Midwives in the geographic area of your search.

**Note:* this same tool can be used to find Certified Nurse-Midwives (with "Board of Registered Nursing" selected in the "Board or Bureau" drop-down tool, and "Nurse Midwife" selected in the "License Type" drop-down). However, this tool is not useful for finding community-birth certified nurse-midwives, as the search results do not distinguish between community and hospital midwives.

Professional Associations.

- **California Association of Licensed Midwives (CALM):** Visit the CALM website for "Find a Midwife."
- **California Nurse-Midwives Association (CNMA):** Explore the Meet the Midwives project. (Note: only a small number of CNMs in California currently provide community birth services)

A sample form for tracking your findings is located **here.**

1 Do the Research

For Community Birth Providers: Research the Hospital and EMS Ecosystem in Your Area

Community midwives and birth centers may need to take the lead in initiating these partnerships.

Identify hospital liaisons. At your transfer hospitals, you may already have been in contact with key liaisons, such as the maternal–child health (MCH) director, the MCH nurse-manager, and the perinatal nurse educator. Using the CBPI introductory flyers and website, consider calling Labor & Delivery directly and letting them know you are a community midwife and are interested in the CMQCC initiative for community birth partnership. Then ask to speak with any of the above titles, or leave your direct phone number and name for a return call.

Map EMS agencies and learn about your local EMS services. Each county has a Local EMS Agency (LEMSA) that oversees ambulance and paramedic services. Determine whether multiple EMS *providers* (e.g., AMR, Alpha One, Falck, etc) cover your area, and learn how your local LEMSA(s) operate.

- Each **LEMSA directory** includes the names of key administrators, and sometimes email addresses. Consider emailing the contact person or the county administrator listed on your LEMSA's website.
- If this does not yield a response, county Medical Directors (physicians) may also be able to route you to a key person at your LEMSA. A list of county Medical Directors is located **here.**
- If you already know the EMS provider or providers in your county, reach out to one you have worked with during a previous transfer, and ask to speak with the Director of Operations, or leave your direct contact information for a return call or email.
- Many counties utilize their county or city fire department as the first responder. If this has been your primary experience during transfers, contact the county or city fire department and ask for the best person to contact regarding this project; leave your direct contact information.
- See **Appendix A** for California-specific information for midwives about the EMS system.

Build your contact list. Create a reference list with key contacts at the facility you aim to work with, such as MCH director, MCH charge nurse, the EMS liaison you have identified, and others relevant to your practice setting. .

RESOURCES FOR STEP 1

- DCA license search
- Local EMS Agencies
- Template Midwife Tracking Form
- California Association of Licensed Midwives (CALM) "Find a Midwife" tool
- California Nurse-Midwives Association (CNMA) "Meet the Midwives" project

2 Assemble the Team

The core triad of the Perinatal Transfer Improvement Committee includes:

- 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).

The committee may also include doulas, community advocates, and individuals with transfer experience, whose perspectives can help ensure the process reflects the needs of families and the wider community.

For detailed guidance on establishing partnerships, building a collaborative workgroup, and establishing a work plan, see the "Readiness Section" of the ***AIM Community Birth Transfer Resource Kit***.

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

Before bringing hospital staff and community midwives together, it is essential that hospital and EMS team members understand the current landscape of midwifery in California and the best practices for community-to-hospital transfers. This orientation reduces misconceptions and sets the stage for a more productive and collaborative dialogue with midwifery partners. A suggested framework is provided below.

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

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

3 Pre-Meeting Education for EMS and Community Midwives

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*

RESOURCES FOR STEP 3

- CMQCC CBPI Slide Deck for EMS
- CMQCC: Community Birth Partnership Initiative Webpage
- CMQCC: California Midwives Are Essential Maternity Care Providers (PDF)
- CMQCC: Frequently Asked Questions About Transfer (PDF)
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- 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

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

As with any QI initiative, it is essential to have a designated lead(s) to coordinate meetings, document discussions, and follow up on outstanding tasks. In most cases, a hospital champion—such as a nurse manager—and a community midwife liaison are well-suited to share these responsibilities. These two leaders 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 first meeting should focus solely 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.

At the conclusion of this meeting, the facilitator(s) should remind participants to review resources in this guide before the next meeting, with particular emphasis on:

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

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

The second meeting is where the work begins! This meeting should focus on intrapartum transfers and consider both urgent and non-urgent transfers. Utilizing best practices resources (see below) and the Template Transfer Guideline, begin discussing each point and tweaking the template to suit the needs of your hospital and regional midwives. Remember, Rome wasn't built in a day. Developing these guidelines will take time. Creating space for thoughtful, nuanced conversations is essential, as this is how issues and concerns are surfaced and worked through.

Monthly 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).

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)

In-Person Meeting. It is recommended that the Perinatal Transfer Improvement Committee convene a face-to-face meeting to build relationships, refine transfer guidelines, and reaffirm shared goals. The Community Birth Partnership Pilot teams found it it helpful to meet in person after the initial intrapartum guidelines were completed (or nearing completion). During these 2-4 hour events, teams reviewed their current guidelines, received input and education from EMS partners, and provided short education sessions that improved understanding of opposite birth settings. While food is not required, sharing a meal can enhance team-building.

Quarterly Meetings. When the team transitions to quarterly meetings, the meetings should focus on:

- Suggested changes to the guidelines based on actual transfers and transfer experience surveys
- Any guidelines not yet discussed, e.g., newborn transfers, emergency postpartum, etc. Specific issues during transfers that need attention, e.g., communication, direct admission policies, and EMS interactions.
- Designing the process for debriefing after a transfer if not already done.

Template Transfer Guideline
(adapted from Smooth Transitions)

6 Simulations

Why Run a Simulation?

California CBPI pilot teams found the on-site simulation to be the most effective tool for preparing teams to handle community-to-hospital transfers smoothly and safely. This is consistent with the results of a recent national collaborative.[14]

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

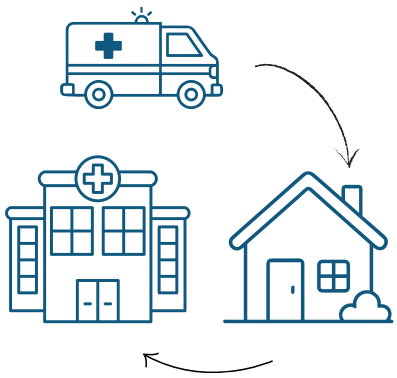
Team-Building & Trust

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.

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

Lasting Change is Achievable with Consistent Effort

The Community Birth Partnership Initiative has given hospitals, community midwives, and EMS teams a foundation for collaboration. Sustaining respectful, effective transfer processes is not a one-time achievement—it requires ongoing attention: relationships must be nurtured, new team members oriented, and small issues addressed before they become bigger problems. This long-term cultivation results in safer transfers, stronger trust, and healthier communities.

☑ 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.	

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

7 Sustain the Work

Building Enduring Partnerships

Participants in the CBPI engaged in four impactful practices to sustain collaboration and mutual respect:

1. Shared educational sessions, e.g. Grand Rounds, Project Echo (see below)
2. High-fidelity drills from a community setting to the hospital to strengthen teamwork and real-time communication (see Step 6)
3. Birth center visit with Q&A to deepen understanding of midwife-led care, risk assessment, and the transfer process in community settings
4. Ongoing open communication among the core triad (hospital, community midwives, EMS) to maintain accessibility and build collegiality

Team-Building Activities Beyond the First Year

Participants in the CBPI submitted the following ideas as potential co-learning experiences to sustain collaboration and improve communication between the hospital, community midwives, and EMS:

- Present at Grand Rounds (community midwives for hospital staff, or by hospital staff for community midwives, on an identified topic of interest)
- Arrange a shadowing experience
- Co-attend:
  - **Advanced Life Support in Obstetrics (ALSO)**
  - A group screening of HIVE CE's **Transfer Tools for Midwives, EMS, and Hospital Providers**
  - Community-based Neonatal Resuscitation Program (NRP) for community midwives and EMS (see programs offered by **Midwives Untethered** and the **American Association of Birth Centers**)
  - **Intermittent Auscultation Simulation-Based Course** (Step Up Together)
  - Regional **Project ECHO** virtual events
  - **Spinning Babies**
- Co-host a learning initiative based on the **Core Modules for ACNM-ACOG Maternity Care Education and Practice Redesign**
- Host a **focused debriefing practice**

Appendix A

California's EMS System: A Primer for Community Midwives

System Structure. In California, the emergency medical services (EMS) system is organized through 33 Local EMS Agencies (LEMSAs) that collectively serve the state's 58 counties. Some LEMSAs oversee a single county, while others cover multiple counties through regional agreements. Each LEMSA manages and coordinates its local EMS system, including developing clinical protocols and response procedures. These protocols are written and approved by the LEMSA Medical Director, a physician responsible for medical oversight of EMS care within the jurisdiction. As a result, some operational details—such as dispatch protocols—are specific to each LEMSA's service area. Additionally, continuing education and training of EMS personnel is provided by local EMS provider agencies (e.g., ambulance providers and fire departments within each jurisdiction).

The system also includes several layers of statewide standardization and oversight. The scope of practice for EMS providers is standardized at the state level. Scope of practice is discussed at quarterly meetings of EMS medical directors and ultimately approved by the State EMS Medical Director.

Overall, California's EMS structure can be understood as decentralized in geographic implementation but centralized in regulatory oversight: local EMS agencies determine protocols and operational details within their regions, while the state establishes the overarching standards that those local systems must follow.

Basics of Call Routing. EMS call routing systems are designed primarily for the general public—not clinicians managing a planned birth. As a result, midwives often report frustration at being asked "irrelevant" questions or when given instructions that do not align with the clinical situation or the care already provided. For example, reporting that the "baby is not breathing" may prompt the dispatcher to instruct initiating chest compressions, even though this would not be standard practice for a newborn. Understanding how the dispatch system works in one's own jurisdiction can help midwives communicate effectively and anticipate next steps.

When a midwife calls 911, the call enters a complex emergency dispatch system. Each county's LEMSA determines the specific dispatch protocols and response matrix. Call routing has multiple triage points. In some (not all) jurisdictions, the medical dispatcher is not the first to receive your call. In practice, this looks like:

- Your call first reaches a Public Safety Answering Point (PSAP), such as a police station or the California Highway Patrol → standardized triage questions are asked → your call is then transferred to the medical dispatch center → The medical dispatcher begins another set of structured questions.

This multi-tiered routing process explains why callers may be asked the same questions multiple times. For these questions, most emergency dispatch centers use standardized questioning protocols developed by the International Academies of Emergency Dispatch (IAED). These scripted protocols—often called "cards"—guide call-takers through a series of structured questions and instructions. There is more than one company that produces these proprietary, standardized cards. LEMSAs often use different proprietary cards, but the questioning process is similar across regions. These cards ensure a rapid, standardized protocol for assessing the situation, prioritizing safety, and coordinating the appropriate public resources. As such, midwives should be prepared for a set of questions about pregnancy and labor/birth in the lead-up to the more pertinent questions about the emergency situation.

Additionally, a California law[1] effective January 1, 2027 requires that all 911 systems include specific "prearrival medical instructions" to the caller, to include at minimum: (1) airway and choking medical instructions for infants, children, and adults; (2) automatic external defibrillator (AED) and CPR instructions for children and adults; (3) childbirth instructions, (4) bleeding control and hemorrhage, (5) administration of epinephrine by auto-injector for suspected anaphylaxis, and (6) administration of naloxone for suspected narcotic overdose.

During the call, dispatchers enter information into a Computer-Aided Dispatch (CAD) system, which documents the incident, recommends the appropriate response, and helps coordinate the dispatch of emergency resources. First responders receive these CAD notes in real time while en route, allowing them to view updates on the situation as they travel. As a result, while the midwife may be answering several questions during the call, the responding team is simultaneously receiving a more complete picture of the situation than the questions alone might suggest.

> ***Importantly, dispatchers typically **do not wait to send first responders** before continuing with questions. Answering additional questions or receiving instructions **does not delay the initial dispatch** of EMS services; rather, it helps ensure that the most appropriate resources and guidance are provided as efficiently as possible.*

Be Clear About What Resources Are Needed. Dispatchers rely on the information provided by the caller to determine an appropriate response. Often, the dispatcher will say, "Tell me exactly what happened." Midwives should clearly communicate the situation, ideally in an easy-to-follow SBAR format (see Smooth Transitions 911 Protocol **here)**. Be sure to include:

- That you are a licensed provider giving care onsite for a planned community birth.
- Who requires emergency assistance (the client, the baby, or both).
- The primary clinical concern is stated in plain, non-technical language. **Note:* Dispatchers are familiar with general medical terminology but may not be familiar with obstetric-specific language. Use clear, descriptive terms—for example, say "gestational age" instead of "GA," or "first baby" instead of "nulliparous."
- Whether active resuscitation or urgent intervention is occurring.

EMS Response Levels. The dispatch center determines the type of responders sent to a scene based on the information provided and available resources within the county or region.
California EMS systems categorize responses as:

- Advanced Life Support (ALS) – Paramedic-level response for potentially life-threatening conditions (e.g., defibrillation, intravenous or intraosseous access, IV medications, advanced airways).
- Basic Life Support (BLS) – EMT-level response (e.g., unexpected birth, AED, splinting, tourniquet, O2, epinephrine; BLS in certain regions (not all) may do supraglottic airways).
- Specialty responses – In rare cases, additional resources may be deployed, such as a critical care air ambulance transport.

First Responders Vary. Depending on local resources and availability, the first responders may include:

- Fire department personnel, then ambulance transport.
- Paramedic ambulance crews.
- EMT crews.
- Law enforcement officers.

In many systems, a fire engine may arrive first, but not all fire units carry paramedics. Some engines provide BLS-level care until a paramedic unit arrives.

Debriefing is Important. Whenever possible, include EMS providers in the debrief process—not just the hospital team and the midwife. One way to facilitate this is to obtain the name or badge number of the responding EMS personnel at the time of the transfer. You can then contact your Local EMS Agency (LEMSA) to request a joint debrief and invite the EMS providers who assisted with the case. If an EMS provider voluntarily shares contact information, consider following up while the event is still fresh. In some situations, if time and circumstances allow, a brief on-scene debrief may also be possible.

Including EMS in debriefs supports shared learning and system improvement and can help address the mental health and stress that emergency responders may experience after difficult calls. Some EMS agencies have their own structured debrief processes, so coordinating through the LEMSA may be the most effective approach. Using language such as “inviting EMS to participate in a joint debrief”—rather than asking for one—can help frame the conversation as a collaborative quality-improvement effort. Additionally, contacting the LEMSA may be helpful, as EMS providers may be reluctant to share personal contact information due to the highly litigious environment in which they work.

Understand Your Local EMS System. Because systems vary by county, midwives are strongly encouraged to learn how their local EMS and dispatch systems operate. This is especially important for midwives who practice across multiple counties, where expectations may differ. Some midwives choose to create their own quick-reference dispatch cards tailored to their local jurisdiction. Getting to know your local EMS system also helps the midwife understand the local protocols and which medications are available to first responders. For example, medications typically used in obstetric emergencies, such as pitocin, TXA, or antihypertensives, may not be locally available per protocol.

A practical strategy is to contact the dispatch center before an emergency occurs. Midwives can:

- Call the non-emergency number for the 911 center.
- Request to speak with a dispatch supervisor.
- Ask to learn more about what dispatchers will ask for during a call so that you can be prepared to quickly and efficiently respond.
- Ask about the protocols the center uses for childbirth and neonatal resuscitation emergencies, and whether the protocol changes for a licensed health care provider or health care facility. **Note:* Some agencies utilize "**Protocol 37** for health care providers." This protocol is used when a health care center or provider calls for EMS support. It was created because health care provider calls differ from typical 911 calls from the public, and allows the dispatcher to rely more on the caller's clinical assessment and focus on selecting the correct ambulance response level and resources. However, simply saying you are a midwife *does not trigger P*rotocol 37. Thus, the midwife should work with the dispatch center to determine whether this change is possible.
- For planning purposes, ask for information about the standard EMS response times for the regions you serve.

In addition to contacting the dispatch center, contacting the LEMSA is also encouraged. Working with your local agency may create opportunities to provide input on process improvements and local protocols.

- Your local EMS agency (LEMSA) can be found **here;** if unsure, use **this map** to find your LEMSA's name.
- A list of local EMS *providers* (e.g., ambulance companies) is provided **here.**
- An ArcGIS map of Fire Stations/EMS Stations can be found **here.**

Key Takeaways for Midwives

- Dispatch systems are designed for lay callers, not clinicians.
- Responders are usually *dispatched early in the call,* even while questions continue.
- Clear, concise information helps dispatch send the appropriate resources.
- Dispatchers will provide mandatory scripted care instructions.
- EMS response levels and arrival times vary by county and available resources, and are determined by the system, not the midwife.
- Debriefing is important for EMS; it provides an opportunity to learn and also reduces mental stress (EMS providers rarely receive follow-up information about transports).
- ***Know your local system!*** Becoming familiar with your local EMS dispatch system and LEMSA will improve communication during emergencies, help the midwife anticipate the flow of triage questions, and may create opportunities to provide input on local protocol and dispatch process improvements.

1. *California Code, HSC 1797.161*

Toolkit References

1. American College of Obstetricians and Gynecologists. *Transfer Protocols for Out-of-Hospital Birth.* Published December 10, 2025. Accessed March 3, 2026. https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2025/transfer-protocols-for-out-of-hospital-birth
2. Levine A, Souter V, Sakala C. Are perinatal quality collaboratives collaborating enough? How including all birth settings can drive needed improvement in the United States maternity care system. *Birth.* 2022;49(1):3-10. doi:10.1111/birt.12600
3. Akerson S, Taiwo TK, Denmark MA, et al. Quality improvement in community birth: A call to action. *J Midwifery Womens Health.* 2022;67(5):544-547. doi:10.1111/jmwh.13398
4. Alliance for Innovation on Maternal Health. *Community Birth Transfer Resource Kit*. American College of Obstetricians and Gynecologists; August 2024. Accessed March 11, 2026.
5. Felix K, Shim RS. Community innovations to improve black maternal health. *JAMA Health Forum.* 2025;6(8):e254411. doi:10.1001/jamahealthforum.2025.4411
6. Gregory EC, Osterman MJ, Valenzuela CP. Changes in Home Births by Race and Hispanic Origin and State of Residence of Mother:United States, 2019-2020 and 2020- 2021. *Natl Vital Stat Rep.* 2022;71(8):1-10.
7. California Health Care Foundation. *California Maternity Care Almanac.* September 23, 2025. Accessed March 1, 2026. https://www.chcf.org/resource/maternity-care-almanac/.
8. California Code, BPC 2746.54 and BPC 2508.
9. California Code, BPC 2510
10. California Health Care Foundation. *Midwifery Care in California.* October 24, 2025. Accessed March 11, 2026. https://www.chcf.org/resource/midwifery-care-california/
11. Booth J, Breedlove G. *Vicarious liability: addressing barriers to midwifery practice—2019 and beyond.* Grow Midwives LLC; 2019.
12. Pettker CM, Thung SF, Norwitz ER, et al. Impact of a comprehensive patient safety strategy on obstetric adverse events. *Am J Obstet Gynecol.* 2009;200(5):492.e1-492.e4928. doi:10.1016/j.ajog.2009.01.022
13. Hays K, Denmark M, Levine A, de Regt RH, Andersen HF, Weiss K. Smooth Transitions: Enhancing interprofessional collaboration when planned community births transfer to hospital care. J Midwifery Womens Health. 2022;67(6):701-706. doi:10.1111/jmwh.13441
14. Romano A, Dougherty A, Johnson J. Tools, Coaching, and Community to Support Interprofessional Emergency Transfer Drills: Results from a National Action Collaborative Focused on Birth Center to Hospital Transfer. J Midwifery Womens Health. 2025;70(6):952-959. doi:10.1111/jmwh.70005

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