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Practice Summary & Implementation Guidance

Strengthening Community & Facility Networks of Care
Quality Improvement in Action

A midwifery model of care in Massachusetts

Cutting-Edge → *Emerging* → *Promising* → *Best*

Location	Topic Area	Setting
Massachusetts	Care Coordination, Birth Outcomes	Community, Clinical

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Population Focus	Date Added
Families & Caregivers, Infant, Medical &Public Health Professionals, Women & Maternal	Summer 2026

Section 1: Practice Summary

PRACTICE DESCRIPTION

Midwives are highly skilled, independent maternity-care clinical professionals who support birthing individuals, their children, and family throughout the reproductive period, pregnancy, labor, birth, and the postpartum period. Community midwives are trained to provide evidence-based planned care in homes and freestanding birth centers to birthing individuals and consult with or transfer care to hospital-based services when needs arise. For people with low-risk pregnancies, evidence shows that midwifery-led care is associated with fewer interventions, stronger continuity and patient experience, and favorable outcomes. A national matched study found that birth-center care provided by midwives was associated with a 12.2-percentage-point lower cesarean rate, a 5.5-point lower neonatal intensive care unit admission rate, and a 9.3-point higher breastfeeding rate at discharge than hospital-based usual care (Wallace et al., 2024). Respectful and collaborative integration of community birth and midwifery care in the maternity care ecosystem is key to ensuring safe birth outcomes. The World Health Organization defines a maternal and infant network of care as intentionally connected healthcare workers and facilities that coordinate across home, community, emergency, primary, and hospital care. A strong network requires clear referral and transfer pathways, transfer plans, shared records, and access to the right level of care, as well as the relationships that make those systems work: communication, role clarity, trust, shared learning, and respectful teamwork (World Health Organization, 2024).

The need to strengthen community birth and midwifery care integration is increasingly urgent in Massachusetts. Demand for community birth is growing while maternity-unit closures, longer travel distances, and uneven access to neonatal intensive care make the care system more fragile. Nationally, Black women are more than three times as likely as White women to die from pregnancy-related causes, and infants of Black women die at more than twice the rate of infants of White women, underscoring the urgency of stronger, more coordinated perinatal systems of care. (Centers for Disease Control and Prevention, 2025; National Center for Health Statistics, 2025) As is true across the United States, in Massachusetts, black, non-Hispanic birthing people experience severe maternal morbidity at approximately 2.5 times the rate of white birthing people (Massachusetts Department of Public Health, 2023). Infant mortality among Black infants is roughly double the state average. The rate of nulliparous, term, singleton, vertex cesarean delivery (NTSV c-section) is 26% with significant variability across facilities, and some hospitals reporting at rates as high as 42.7% (Bebinger, 2015; Cáceres et al., 2013). The state's 2024 *Act Promoting Access to Midwifery Care and Out-of-Hospital Birth Options* established licensure for certified professional midwives and reinforced the need for emergency transfer and care-coordination plans. The policy expands access to community birth options, but safe and high-quality implementation requires community midwives, emergency medical services (EMS), hospitals, public health agencies, and regulators to function as one coordinated network.

Since the passing of the 2024 Maternal Health Law, Massachusetts began building that network through the **Community Birth and Doula Initiative** (MA-CBDI), a Massachusetts Department of Public

Health-led (MDPH) statewide initiative. In 2025, MA-CBDI partnered with Primary Maternity Care's Step Up Together® to conduct seven high-fidelity community-to-hospital transfer drills involving more than 100 providers across 10 practice locations. On April 7-8, 2026, the inaugural Massachusetts Perinatal Networks of Care Summit brought more than 40 providers and leaders together statewide to address identified barriers to optimal community-to-hospital transfers of care. The summit identified priorities directly relevant to transfer safety: hospital preregistration regardless of planned birth location, timely two-way exchange of records, cross-disciplinary education, clarification of regulations, and ongoing facilitated relationship-building. In recognition of the multi-layered systems in which community-based care is delivered, and the multi-agency landscape in which the full continuum of perinatal care is regulated, the practice of **strengthening community & facility networks of care** entails tiered Plan-Do-Study-Act (PDSA) cycles across all levels of the perinatal health system: clinical practice, county or perinatal region, and state.

CORE COMPONENTS & PRACTICE ACTIVITES

The practice centers bringing together multidisciplinary teams of perinatal specialists through high-impact interactions to forge well-functioning networks of care. PDSA methodology is implemented across site, regional, and statewide tiers of the health system to drive rapid quality improvement. Each Plan-Do-Study-Act cycle brings together community midwives, EMS, hospital clinicians and administrators, public health partners, and people with lived community birth-to-hospital transfer experience.

At the site level, drill teams were comprised of a community midwifery practice; a receiving hospital with obstetric services in the same geographic catchment area; and in 50% of the drills an off- service EMS team staged to be deployed for purposes of the drill. Following Step Up Together's ® methodology, each drill team assigned a drill coordinator who ran the clinical scenario, kept time, and facilitated the immediate post-drill review. Each clinical practice was encouraged to choose a clinical scenario relevant to recent challenges. These included: severe, prenatal hypertensive episode; shoulder dystocia and neonatal resuscitation in a planned community delivery; postpartum hemorrhage; maternal request to transfer for epidural pain management; and fetal bradycardia in second stage. Following each transfer simulation, a facilitated debrief encouraged participants to understand one another's scopes of practice, equipment, protocols, decision-making processes, and constraints; as well as identify concrete recommendations, best practices, and areas of improvement. Sites are supported through technical assistance to adopt identified improvements before the changes are once again studied through another drill and debrief cycle.

At the regional level, networks were identified to encompass the full continuum of perinatal care needs. Due to significant geographic diversity in availability of services, some locations of MA can establish a regional network within a single municipality. In other areas, these networks span more than one county. In each, the network comprises community midwifery practices, EMS services, and hospitals providing Level 1 – IV neonatal and maternal care. Key informant interviews (KII) with practice administrators, public health and clinical regulators, and individuals with lived experience of a community-to-hospital transfer were conducted and incorporated into the study phase of the PDSA cycle. Qualitative and quantitative data were gathered to inform cross-drill learning and identification of recommendations for future transfer guidelines.

At the state level, the data collected through drill debriefs, KII, and desk review of vital records and maternal and fetal morbidity and mortality reviews fed into an all-regions perinatal network of care



summit to identify best practices, clarify regulations, and identify improvement actions. Critically, regulators and system governance leaders from facility safety and quality, clinical improvement, professional associations, and emergency medical services are engaged in each PDSA cycle to ensure structural change that supports priority shifts at the regional and site levels. Implemented changes to EMS, birth center, and community midwifery policies are currently in the study phase of our second cycle at the state level.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Intra- and Inter- Site Level	Identify an anchor practice providing community birth care (e.g: freestanding birth center or home birth practice); match to frequent receiving and/or collaborating hospital. Conduct readiness assessment to determine whether the practice will begin with intra-practice QI (such as a condensed series of PDSA cycles to improve provider confidence and/or site protocols for contacting external sites with higher levels of care available); or whether the site is ready to work with its community/hospital counterpart (executing a full drill involving simulated transport of a patient from one location to another). Run the high-fidelity drill using Step Up Together ® drill kit; conduct a post-drill debrief session to identify lessons learned, strengths. Put lessons into practice through changes to workflows, protocols, and recordings.	Use Step Up Together® Transfer Drill Checklists to ensure standard workflows. Map formal and emerging relationships; convene a transfer drill planning group with a lead from each level of care (community birth, hospital, EMS); select a locally relevant scenario (e.g. transfer from a local birth center or home birth) and date for the drill. Each drill requires 1-3 planning calls, day-of preparation, and post drill wrap up. A Transfer Drill Agenda Template, shared with all participants, includes the timeline of the drill with participants, drill addresses, key points of contact, and action items prior to the drill. The Transfer Drill Report Template, adapted from the Step Up Together® drill debrief form, includes drill participant number, what went well, and key recommendations and next steps.
At the Regional Level	Form regional transfer workgroups consisted of community midwifery practices, local health agencies, hospitals within the region providing neonatal and maternal care, and EMS	Include all sites engaged at the site level and partners within the broader perinatal care continuum, such as people with lived experience and public health experts. Initial regional meetings should include

	services in the catchment area for cross-cadre learning, identification of drill learning themes, and prioritization of multi-site quality improvement action steps.	opportunities of cross-drill learning, cross-education on provider scope of practice and relationship-building among the broader network of care. Initial convening requires time for group building. This time is exponential to the number of different practices, organizations, and/or service delivery systems in the regional zone. Allow each region to identify the least disruptive time and location to convene. Ensure in-person attendance and facilitation.
At the State Level	Consolidate and analyze data and learnings collected at practice and regional level; engage with statewide agencies including but not limited to Bureau of Healthcare Safety and Quality and Office of Emergency Medicine. Host in-person statewide perinatal transfer and network of care summit that includes time for relationship building, exploration and identification of misinformation, and action-oriented work planning on improvement steps to take in the coming year.	Steering committee of key leaders in each provider cadre is formed prior to the summit for agenda review and identifying key participants. State regulatory and oversight agencies are engaged months before the statewide convening for relationship-building and cross-learning. Participation of individuals providing frontline care as well as administrative and policy leaders is crucial. Schedule with sufficient advance notice to enable attendance of clinical providers. Invest in residential setting, relationship building opportunities in the agenda, and sufficient time or participants to take the agenda in unexpected directions. Budget for meals, accommodation, and childcare support.

COMMUNITY WELLNESS

S**trengthening community & facility networks of care** improves relationships across the care provider continuum by fostering stronger working relationships between community-

based and hospital-based providers. This not only contributes to improved patient care and maternal and neonatal outcomes. It also contributes to improved provider well-being and reduced work stress. Barriers to optimal collaboration, timely transfer of care, and appropriate provider-to-provider handover of clinical information not only stem from regulatory barriers. Systemic distrust between community and hospital providers as well as between physicians and midwives are a significant contributing factor. While complex in origin, much of this distrust dates back to the early 20th century and key historical events such as the publication of the Flexner Report (Flexner, 1910). When traditionally siloed perinatal providers come together around a stressful event like an emergency transfer in a high-fidelity simulation, the result provides opportunity to examine bias, improve transfer systems and protocols, and learning among diverse provider types. In this controlled setting, they can learn about their training, unique skill sets, management of adverse outcomes, and methods for shared decision making with patients. Importantly, providers and policy makers also gain opportunity to unpack situations that may cause secondary trauma, experience newfound respect from colleagues, and have an opportunity to feel valued by the system in which they work.

EVIDENCE OF EFFECTIVENESS

Evidence of effectiveness is assessed at multiple levels, combining implementation progress measures with emerging evidence of improved practice outcomes. The MA-CBDI initiative routinely tracks the following metrics:

- Site level: increased number of providers participating in transfer drills; number of sites completing the transfer protocol data form; number of partial transfer drills completed; number of full transfer drills completed; and number of perinatal sites with community-to-hospital transfer continuous quality improvement plans.
- Regional level: increased understanding of and respect for the roles of different provider cadres within a perinatal network of care; participants report of more frequent positive transfer experiences; and increased consistency and clarity of roles and responsibilities across networks of care statewide; number of regions conducting multi-site PDSA cycles.

Within the first year of the practice, we have demonstrated measurable success:

- At the site level, seven drills were conducted during the action collaborative, involving more than 100 health workers across 12 disciplines and 10 practices. Since then, four sites have independently conducted repeat Plan-Do-Study-Act cycles. 8 of the 10 practices engaged report increased cross-cadre understanding and mutual respect. 6 of 10 sites report increased clarity of roles and responsibilities.
- At the regional level, three regions are independently implementing relationship-building activities across networks of care, and the first regional transfer workgroup is formed in North Shore.
- At the state level, following the inaugural Massachusetts Perinatal Networks of Care Summit, The Department of Public Health has developed its first inter-bureau memo between the Bureau of Family Health and Nutrition and Bureau of Healthcare Safety and Quality on clarifying regulations for transfer of care, allowing for improved communication and collaboration across hospital and out-of-hospital providers when providing care for families.

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

Issues related to poor networks of care, limited integration of community birth into perinatal health systems, and lack of community-to-hospital perinatal transfer protocols deeply impact both providers and birthing families. The practice engaged providers at all stages of a perinatal emergency transfer and transport to learn from past experiences and identify recommendations for future improvements. Following each transfer drill, a facilitated debrief engaged participants. In addition, through key informant interviews (KII), the program engaged individuals who experienced community-to-hospital emergency transfer during their own labor, delivery, or immediate postpartum to better understand how different potential systems impact patient experience. To ensure lasting structural improvement, PDSA cycles are also supported at state level, drawing on the learning themes from individual practice and regional drills.

Practice Collaborators and Partners			
Partner/ Collaborator	How are they involved in decision-making throughout practice processes?	How are you partnering with this group?	Does this stakeholder have lived experience/come from a community impacted by the practice?
Massachusetts Department of Public Health (DPH)	Provides funding support and strategic support on facilitating multi-disciplinary collaboration across provider types. Provides regulatory support to address barriers and challenges through policy and systems standpoint.	Quarterly reports and meetings are held with DPH bureaus overseeing pregnancy and infancy care facility oversight, emergency medicine, clinical improvement, and professional associations.	Yes, leadership at DPH include individuals who have given birth out of hospital, practiced as a midwife, or been on the receiving end as an emergency medicine provider.

Education Development Center	Provides technical assistance in the implementation of core components. Serves as convener of the various collaborators to ensure effective implementation	Convenes partners; manages planning, communication, data synthesis, and follow up; and supports toolkit development.	Yes, project director is a midwife who has pr ovided care in out of hospital settings and been on both sending and receiving end of transfers. Technical assistance associate is a midwife who has extensive experience receiving transfers within hospital settings.
Primary Maternity Care (Step Up Together ®)	Provides subject matter expertise in community birth transfer simulation, clinical quality improvement, and multidisciplinary debriefing.	Adapts scenarios, supplies the drill methodology.	Yes. The team includes midwives and maternity-care professionals with direct experience in community birth and transfer.
Community midwives and Massachusetts Chapter of NACPM	Bring the perspective of providers who practice the midwifery model of care, are skilled out-of-hospital birth providers, initiate transfer of care when needed, support patients with continuity of care, and communicate with EMS and hospitals.	Co-design scenarios and transfer pathways; participate in drills, debriefs, the summit, and recommendation review.	Yes. They are independent, primary perinatal care providers with experience delivering out-of-hospital and engaging community transfers.
Clinical providers (obstetricians, neonatologists, emergency pediatrician, emergency medicine physicians, nurses, CNMs)	Represent the hospital teams receiving transferred birthing people and newborns and identify barriers in triage, handoff, and escalation.	Participate in planning, drills, debriefs, and the summit; test hospital workflows and identify facility changes.	Yes. They directly receive and care for transferred patients.

EMS partners (local and regional EMS providers, paramedics)	Provide expertise on logistics and mechanisms regarding transferring patients from home or birth center to hospital in an ambulance during planning, drills and debrief.	Participate in planning, transfer drills, debriefs, and protocol review; and communication.	Yes. EMS partners directly transport community birth patients and newborns.
People with lived experience of giving birth out-of-hospital and transferred to hospitals	Bring patient and family perspectives on safety, dignity, autonomy, communication, bias, and continuity of care.	Participate in interviews; themes inform statewide recommendations and the Massachusetts transfer toolkit.	Yes, they have lived experience of out-of-hospital to hospital transfers either prenatally, during labor, or postpartum.

REPLICATION

While the full practice model has not yet been replicated outside of Massachusetts, one of its core components at the site-level—transfer drills using Primary Maternity Care's Step Up Together® community-to-hospital transfer drill kit and action collaboratives—has already been implemented in other states and successfully adapted by a wide range of birth centers, and midwifery practices.
To replicate the full practice as tested in Massachusetts, coordinated action and engagement at the practice, regional, and state levels is essential. Before replication, implementers should assess local law and regulation, governance structure, licensing and scope of practice, EMS routing and points of entry, hospital levels of maternal and neonatal care, the availability of community-birth providers, and the history of relationships among partners.

INTERNAL CAPACITY

This practice began after the passage of the Massachusetts 2024 Maternal Health Omnibus, expanded access to midwifery and out-of-hospital birth. The new policy landscape also made safe, coordinated community-to-hospital transfer systems an urgent implementation priority.
The Massachusetts Community Birth and Doula Initiative, led and funded by the Massachusetts Department of Public Health, serves as the implementation body for this work. DPH provides financing, strategic direction, statewide convening authority, and regulatory support. Education Development Center provides technical assistance, strategic planning, facilitation, implementation coordination, quality-improvement support, partner engagement, and cross-site convening. Primary Maternity Care's Step Up Together ® serves as the subject-matter expert, contributing the transfer drill kits, facilitation, and clinical expertise.



The practice was developed collaboratively with community midwives, maternity-hospital clinical and administrative teams, EMS, doulas, regulators, and people with lived transfer experience. Partners mapped local networks, selected scenarios, participated in drills and debriefs, identified corrective actions, and contributed to statewide learning. This shared-development model is essential because a successful perinatal care transfer requires collaboration and communication across provider types.

PRACTICE TIMELINE

The Massachusetts pilot was implemented as an iterative PDSA continuous quality improvement practice across site, regional, and state levels of the perinatal health system. Timing varies by network size, partner availability, state governance structure, and leadership buy-in at all levels; the durations below are rough estimations and are subject to change based on network needs.

Phase: Planning/Preparations		
Activity Description	Time Needed	Responsible Party
Site Level: Select a site to host a transfer drill; define the practice catchment area; map the local transfer pathway across community birth, hospital, and EMS; identify site leads; select drill scenario and drill date; host a planning meeting to review protocols, roles, and logistics.	Approximately 1-3 months	Education Development Center (MA-CBDI Program)
Regional Level: Map the regional network of care (including availability and number of community midwives practicing in the region, maternity hospitals, hospital with neonatal care capacity); convene a regional transfer workgroup; host an initial meeting with the regional transfer workgroup.	Approximately 3-4 months	Education Development Center (MA-CBDI Program)
State-level: Engage statewide associations, state regulatory and oversight agencies, and key system leaders; form a statewide steering committee for summit; establish processes for collecting and synthesizing findings across practice and regional activities. Identify venue, arrange accommodation logistics, and arrange facilitation.	Approximately 6-7 months	MA Department of Public Health; Education Development Center

Phase: Action

Activity Description	Time Needed	Responsible Party
Site Level: Run the drill; conduct debrief; agree on timing for next drill.	3-4 hours; semi-annually	Participating clinical practice (e.g. birth center; hospital)
Regional level: Host a regional transfer drill or workgroup meeting, bringing participating sites together for cross-drill learning; review patterns and recommendations across drills; support provider cross-education.	4-7 hours; quarterly	Education Development Center (MA – CBDI program) during pilot year. Long-term: sitting chair of the regional workgroup
State level: Host a statewide perinatal network of care and transfer summit	Two days; annual	Education Development Center

Phase: Sustainability

Activity Description	Time Needed	Responsible Party
Site Level: Update protocols and job aids; provide staff with continuing education if identified.	1 – 3 months	Service delivery site leads
Regional Level: Update protocols, job aids, and standard informed consent documents	1 – 3 months	Regional transfer steering group
State Level: Refine and disseminate statewide guidance, tools, and regulatory clarification	Ongoing	Massachusetts Department of Public Health

PRACTICE COST

Costs will vary for replication depending on the scale of implementation, the number of participating sites and regions, the extent of in-person facilitation and convening support required, and whether

partners are able to contribute staff time, meeting space, or other resources in kind. Total cost for 12-months of planning, start-up, and implementation at a statewide scale in Massachusetts was $546,000. This cost covered multiple implementation partners include Primary Maternity Care and Education Development Center; and comprises personnel costs, development of new Step Up Together (R) transfer drill toolkits; in-person technical assistance and facilitation support for drills; local travel; logistics, materials, and accommodations for the statewide summit; behavior change communication materials; and organizational overhead costs. For more information on startup costs and budget considerations at the site-, regional-, and state-level, please contact Rebecca Herman, Program Director, at rherman@edc.org. For more information on the DPH Community Integration Program, contact DPH-communitybirth@mass.gov

LESSONS LEARNED

During the first year of implementation, this cutting-edge practice revealed many lessons both on the technical interventions themselves, as well as on enablers and barriers to successful implementation.

Technical Intervention

- It is critical to bring the full diversity of partners across perinatal networks of care across into one collaborative process. This extends to partners who are not traditionally engaged in perinatal care quality initiatives such as EMS and Emergency Departments. Many of the PDSA cycles revealed that too often a community practice and receiving hospital begin to address transfer and collaboration issues, without involving EMS or the ED. Introduction of this practice should include a careful review of EMS points-of-entry protocols when developing, reviewing, or updating community birth transfer guidelines because those protocols influence where patients are taken and how they enter a facility.
- Regional and statewide learning cycles revealed that several of the major contributors to delays in transfer arise out of regulatory confusion or lack of alignment between regulations governing different parts of the networks of care.
- There is a problematic lack of consistency in site-level availability of equipment and supplies—extending from community midwifery practices to public and private EMS services. For example, in Massachusetts, each of the 351 municipalities is covered by different EMS service providers with varying levels of training, from Emergency Medical Technicians with basic first aid training to Paramedics with advanced life support training. Regional transfer working groups find significant benefit in making time to review and work toward consistency in which service sites and provider types will be using and have access to which equipment and supplies.
- Essential network functions include simple referral pathways, the ability for clients to preregister at a nearby hospital regardless of their planned birth location, and timely, two-way sharing of care notes and records between hospital and community-based providers.
- Publicly available information about each facility's maternal and neonatal level of care would help community providers, families, and EMS identify the most appropriate destination when consultation or transfer is needed.

Implementation Learning:

- Intentional layering of site-level quality improvement cycles with learning and action cycles at regional and state level helps ensure that local learning can translate into actionable steps, and systemic changes.

- Planning for, running, and following up on PDSA cycles requires significant administrative coordination as well as subject matter expertise. Early engagement of administrative staff amongst participants and partners is key to success.
- Due to high rates of workforce burnout and understaffing, recognition and other incentives are important enables of success. Implementers should budget to provide light refreshments; make time to ensure action days are a positive break from routine work; and may need to consider stipend support in areas that are particularly under-resourced.
- Seek and cultivate champions from each partner group and provider type you will be engaging in this practice. For example, include state chapters of national professional associations such as American College of Obstetricians and Gynecologists, National Association of Certified Professional Midwives, American Academy of Pediatrics, American College of Nurse-Midwives, and Association of Women's Health, Obstetric and Neonatal Nurses. Due to power dynamics and historical mistrust, most perinatal providers are resistant to being influenced by members of other cadres.

NEXT STEPS

Our next steps include consolidating findings from the pilot drills, lived-experience interviews, and the April 2026 statewide summit into a Massachusetts-specific community transfer toolkit and interactive transfer map. Proposed content includes best practices for transfer planning and preparedness; guidance on risk-appropriate receiving facilities and routinely available equipment; options for preregistration and exchange of antenatal and transfer records; EMS points-of-entry considerations; and policy or regulatory recommendations. We will also continue supporting regional transfer committees and work groups with transfer drill facilitation and implementation of changes, including improving communication pathways, cross-education opportunities, record-sharing, and role clarification. At the state level, our next steps include official rollout and dissemination of an inter-bureau transfer memorandum across state agencies, regions, practices, and providers.

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APPENDIX

- Appendix A: AMCHP 2026 poster - Strengthening Community & Facility Networks of Care: Quality Improvement in Action.