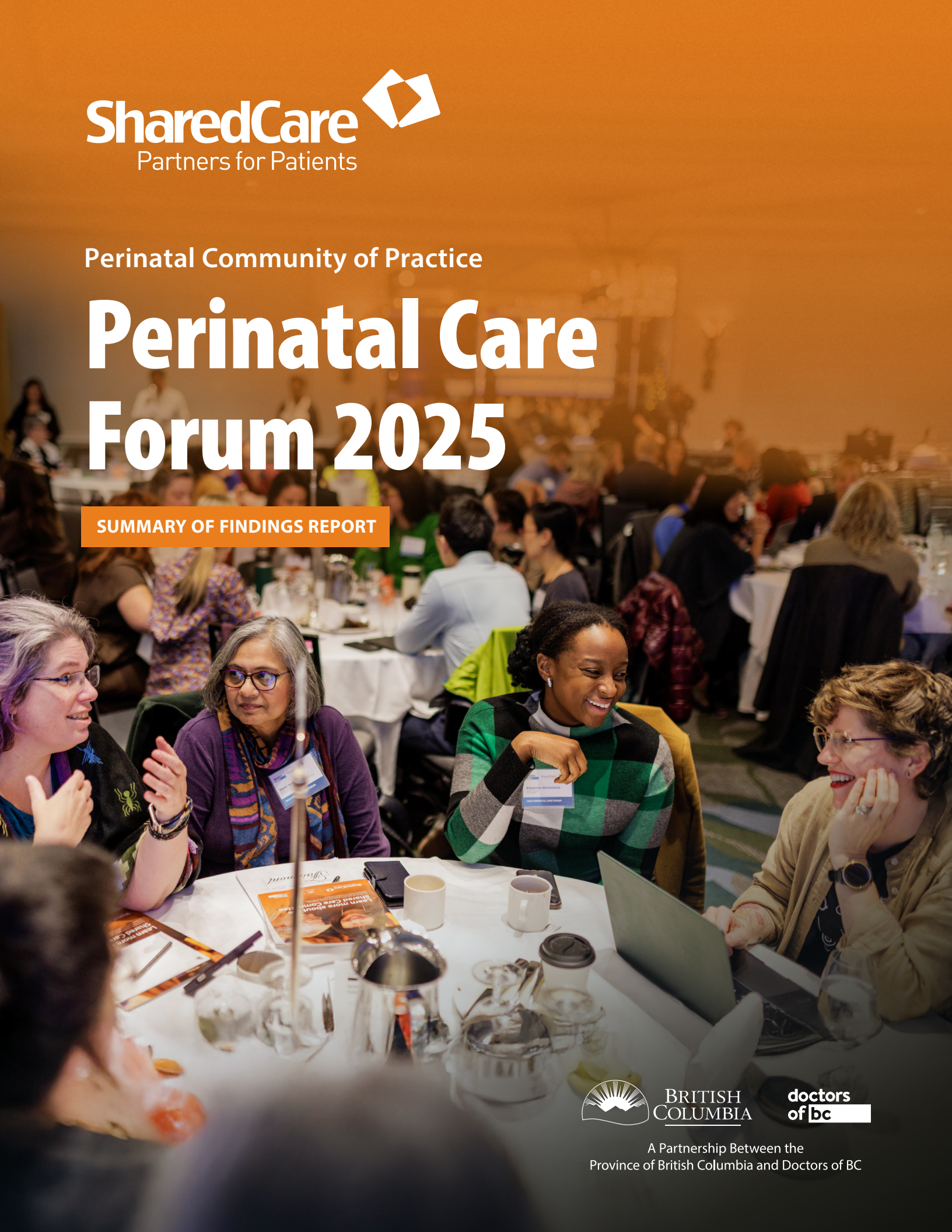
SharedCare
Partners for Patients

Perinatal Community of Practice

Perinatal Care Forum 2025

SUMMARY OF FINDINGS REPORT



BRITISH COLUMBIA

doctors of bc

A Partnership Between the
Province of British Columbia and Doctors of BC

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SUMMARY REPORT

Building sustainable maternity care together

Perinatal Community of Practice, 2026

Executive summary

Background

British Columbia is at a pivotal juncture in shaping the future of perinatal care as the system experiences unprecedented pressure. Patients, particularly those without a family physician, are experiencing increasing challenges to accessing equitable and timely maternity care. Maternity care providers are struggling with moral distress, compassion fatigue, and burnout due to staffing shortages, lack of resources, overwhelming workloads, and frequent service diversions. To address these mounting challenges, the Perinatal Community of Practice (CoP)—an initiative of the Shared Care Committee—hosted the Perinatal Care Forum in Vancouver on November 14, 2025. The event brought together more than 100 diverse participants, including family physicians, specialists (e.g., OB-GYNs), midwives, nurses, allied health professionals, and system partners from across British Columbia. The event focused on building sustainable maternity care by fostering collaboration, leveraging existing resources, and strengthening perinatal teams.

This report summarizes key themes and recommended actions based on a synthesis of structured collaborative discussions held during the Forum, along with ongoing member engagement through CoP

activities from November 2025-June 2026. It captures the voices, experiences, and priorities of those at the forefront of perinatal care. The findings have informed the 2026-28 Perinatal CoP strategic plan, Shared Care's strategic priorities for pregnancy and newborn care, and, more broadly, support informed decision-making and health system improvement. Serving as a resource for perinatal care professionals and system partners, including the Ministry of Health (HLTH), health authorities, Perinatal Services BC (PSBC), Midwives Association of BC, Doctors of BC, and the Joint Collaborative Committees (JCCs), the document provides a foundation for planning, ongoing collaboration, and collective action.

Overview of key priorities

The Forum provided health care professionals and system partners from across the province an opportunity to reflect on strengths, challenges and opportunities in building sustainable maternity care together. Throughout the day, participants reflected on key topics, including building effective perinatal care teams, enhancing collaborative learning models to improve recruitment and retention, and provincial efforts to align and develop integrated approaches to advancing perinatal care in BC.

Across all breakout sessions, which centred on the voices of perinatal care professionals, key themes emerged that outline critical system improvement priorities needed to build sustainable maternity care in BC. Consistently identified areas of improvement included cultural safety and trauma-informed care, funding and payment models, team-based care, retention and recruitment, and resource allocation.

Overview of recommended actions

Based on these themes and priorities, the Perinatal CoP Steering Committee recommends the following joint actions to strengthen and sustain perinatal care in BC.

Cultural safety and trauma-informed care

1. Support perinatal providers and teams to embed culturally safe, trauma-informed care into practice, engaging Indigenous partners to promote equity and accessibility.
2. Promote learning sessions on serving Indigenous populations through Indigenous storytelling, human connection, experiential learning, and team conversation.

Team-based care

3. Fund peer support, role modelling and mentoring within teams to build professional confidence.
4. Support Primary Care Networks (PCNs) and regional teams to develop and implement perinatal strategies for rural and urban communities. Engage Divisions of Family Practice, Medical Staff Associations (MSAs/Facility Engagement), and Urgent and Primary Care Centres (UPCCs).
5. Promote practice supports (e.g., models, guides, tools, digital referrals) to support seamless care and give each community the resources to implement their own team-based care models based on a provincial framework.

Funding and payment models

6. Modernize funding models to reflect the complexity and time commitment required in maternity care, with an emphasis on equity across regions and professions, and to further enable team-based care.
7. Explore compensation models to encourage midwives to provide intrapartum care and flexibility in nurses' rotations and shifts.

8. Streamline credentialing and privileging processes to facilitate timely coverage and workforce integration.

Retention and recruitment

9. Promote mental health and peer support resources focused on burnout prevention and moral injury to ensure the well-being of maternity care professionals, especially those navigating extreme challenges in their communities.
10. Enhance education and training opportunities for new and existing providers, including exposure to longitudinal and community-based primary maternity care, knowledge sharing and role modelling to build capacity and confidence. Focus on building incentives to encourage obstetrics as a profession.
11. Co-create strategies with medical school leadership to facilitate longitudinal maternity care learning to influence residents' interest in maternity care and women's health. Work towards consistent educational experiences across health authorities so core competencies include exposure to the full spectrum of maternity care (including normal births, acute care, and reproductive health).
12. Offer equitable recruitment incentives, including bonus payments for commitment and housing support, and co-create a centralized locum pool with adequate incentives.

Resource allocation

13. Invest in physical space, staff, and incentives—especially in rural and under-resourced settings to support collaborative care.
14. Develop and implement a strategy to spread successful JCC perinatal projects and initiatives and assess new project proposals, leveraging Perinatal CoP expertise.
15. Establish and resource a collaborative engagement model with health system partners—HLTH, health authorities, PSBC, JCCs—and perinatal providers that embeds Perinatal CoP voice and subject matter expertise in maternity planning and decision-making, and involves system partners in relevant CoP forums to align and advance priorities.
16. Apply robust data systems to inform workforce planning, monitor outcomes, and support continuous improvement.

See pages 9, 11, and 16 for more detailed recommendations.

"Providers need system partners to engage, hear their ideas, plan with their participation, and implement recommendations in ways that build relationships and shared accountability."

Methodology

Breakout sessions

To address critical issues in perinatal care, three structured breakout sessions allowed health care professionals and system partners to jointly explore key topics and share their reflections, challenges, and ideas. Topics included building effective perinatal care teams across the province, the SFU School of Medicine's collaborative learning model, maternity team-based care models throughout the province, and integrated system approaches to advancing perinatal care through the Joint Collaborative Committees and Perinatal Services BC.

To encourage diverse perspectives and collaboration, each participant was assigned to one of 15 tables, with six to eight people per table, for the entire event. Each table included representation from rural and urban health care professionals, as well as diverse perinatal care providers, including family physicians, obstetricians, midwives, nurse practitioners, and nurses. Rounding out the tables were representatives from health authorities, Divisions of Family Practice and other system partner organizations.

Each table had a facilitator and a notetaker, including members of the Perinatal CoP Steering Committee, the Forum planning committee, and Doctors of BC staff, to guide and document discussions. After each presentation, all groups reflected on the same set of guiding questions.

Qualitative data analysis

Discussion notes were analyzed using Braun and Clarke's six-phase approach: reviewing data, coding key elements, grouping codes into themes, and developing a narrative to highlight main findings. The Perinatal CoP Steering Committee reviewed the analysis to confirm findings and improve reliability.

Detailed insights

This section summarizes key themes, barriers, opportunities, and recommended joint actions from the three breakout discussions hosted at the November 2025 Forum, with supporting examples and anonymous excerpts and quotes from participants.

Breakout #1: Building effective perinatal care teams

Dr Cecile Andreas led a session exploring perinatal team composition across the province and vital conversations for teams to engage in when building effective teams. Participants shared enablers, barriers, and opportunities to strengthen local perinatal teams.

Perinatal team structure across the province

Diverse team composition

Maternity care teams vary in composition within and across regions—rural clinics typically rely on a few providers (sometimes just one physician and nurses), while some urban centres commonly have diverse multidisciplinary teams, e.g., family physicians, obstetricians, midwives, nurses, pediatricians, and allied health professionals (AHPs)). Among AHPs, social workers, medical laboratory and diagnostic technologists are described as integral team members in some areas.

Diverse models and approaches

Maternity care teams also differ in function. There is no single standard model of care; From Central Interior Rural region's small community clinics and Prince George's on-call system to ensure 24/7 obstetrician on call availability, to in-hospital urban clinics, such as St Paul's maternity clinic in Vancouver or Royal Columbian Hospital, which have two family practice obstetrics groups and several midwifery groups—models and approaches are formed and adapted based on unique circumstances. Communities such as Fernie and Squamish exemplify collaborative midwife-physician models, while others lack midwifery support entirely.

PCNs and UPCCs play a key role in supporting teams and clinicians by providing wraparound allied health supports, including mental health services, in some communities.

Many of the models face strain from perinatal professional shortages, growing demand, and limited capacity, regardless of region. Many participants expressed that diversions, unit closings, transfers and alternating closings all question the idea of a team and challenge the building of strong collaborative working relationships. Diversions and similar situations mean health care professionals no longer know everyone on their team, and they often have to work hard to build collaboration within ad hoc teams.

"In our new reality, the concept of team is changing, and we need to rethink how care teams are formed and supported, and how they're working together in these expanded contexts."

Shared strengths and enablers

While many system challenges have driven perinatal health care professionals to redefine their local perinatal teams, participants also shared strengths that continue to enable effective team dynamics. This included:

Relationships

Strong working relationships, mutual respect, and trust were reported as core values among family physicians, specialists, nurses, midwives, other providers and staff, fostering collaboration. Many teams hold regular meetings or huddles to help to build relationships and support interprofessional collaboration. Nurse in Practice was quoted as a strong enabler, where role responsibilities include intake, triage, and outreach. At a system level, participants held a great deal of responsibility to support their colleagues who are navigating immense system challenges and pressure.

"Teams burning out are least able to advocate for themselves. How to support clinicians who are already drowning?"

Strong commitment for patient-centered care

A strong commitment and passion for patient-centred care were recognized as shared team strengths. Participants noted that their passion for quality patient care, culturally safe and trauma-informed care, supporting diverse populations including Indigenous, newcomer and refugee populations, and women's health generally continue to motivate health care professionals to adapt and find solutions.

Many participants, especially in rural and remote communities, shared that they've continued to collaborate under pressure when navigating unit closures, transfers, or diversions. Many shared they've reorganized roles, shared responsibilities based on pregnancy risk levels, and leveraged informal mentorship to manage limited resources.

"How do we keep the passion alive in physicians, midwives, etc.? Once they leave due to burnout or stress they rarely come back."

Education

Members value participating in team-based learning activities, such as Obstetric Simulations; however, opportunities for such education are often constrained by limited capacity and insufficient support. Other integral components of team educational development included role modelling, mentorship opportunities, and team education sessions that included medical students and residents.

"Education is key—learning on the job is not sufficient."

Barriers to building and sustaining effective teams

Key barriers to building and sustaining effective teams include staff shortages, inequitable funding models and financial inequities, limited physical space, and differences in professional culture.

These factors can undermine collaboration and team effectiveness. Additionally, unattached patients further strain the system, and the complexity of patient needs increases pressure on resources. Addressing these barriers requires open conversations to ensure equity and quality in team-based care, as well as proactive planning and resource allocation to support sustainable collaboration.

Retention and recruitment

Motivation among perinatal care professionals is challenged by ongoing system pressures. Fewer physicians, staff shortages, loss of family doctors offering maternity care, and hiring issues increase workloads, contribute to team burnout, and limit maternity services. Members from high patient-volume sites noted that being on call is stressful and feels unsafe without adequate staffing support in place. Rural teams covering wide geographic areas often have limited access to specialist services; some urban sites report a lack of access to specialists such as maternal-fetal-medicine. Further, several teams report inconsistent intrapartum coverage, including a lack of midwifery integration in some regions.

"You lose one or two people, and the group crumbles."

Funding models and remuneration

For family physicians, a major challenge is the compensation discrepancy between practitioners who do the same or similar work, such as hospitalists versus family physicians with obstetrics. When different communities receive different contracts for the same work, it can challenge recruitment in some areas and leave others with inadequate resources. Further, members noted that funding for MaBAL and CHARLiE RTVS is inequitable and negatively impacts clinicians by reducing services.

"Pay discrepancies are a continuing thorn in the side of perinatal practitioners. Hospitalist contracts are very enticing and are a disincentive to do FP-OB work."

Population and patient demographics

Members noted that shifts in population and patient demographics continue to exert pressure on perinatal teams across the province. Population growth in cities like Langley and Surrey has increased birth volumes, and patient complexity further stresses resources and highlights the need for enhanced support and collaboration. Further, members noted that high demand from immigrant and refugee populations, including uninsured patients without funds to pay for services, also continues to exert pressure on teams. Some members noted that patient volumes have grown, resulting in the need to limit volumes to retain practitioners, and agency

nurses are increasingly being used, which costs the most and fragments the team and patient experience further.

"If doctors had the resources to do their jobs, the moral distress would be gone."

System supports

Participants noted system-level barriers that prevent the formation of effective perinatal teams. Limited clinical space was noted as a restriction to connection and collaboration, impacting acceptance of new patients, service expansion, and training opportunities. At one Cowichan clinic, those who should be collaborating can't fit into the allotted space. Changing boundaries and newly formed or temporary teams in both rural and urban settings require extra support to build trust and maintain quality patient care amid unit closures, transfers, and diversions. Members noted that team leadership is crucial, especially when leaders have experience in leadership or maternity care.

What's the next critical conversation your team needs to have?

Participants stressed the need for ongoing dialogue between health system partners—including health authorities and the Ministry of Health—and frontline providers and perinatal leaders. Discussions should focus on tackling systemic barriers, preparing for crises, rethinking team structures, and supporting providers to strengthen collaboration. Themes emerged from insights into the maternity care crisis:

Addressing systemic barriers

Addressing barriers to collaboration—such as perinatal professional shortages, funding issues, financial disparities, limited space, and cultural differences—is key.

"We are asking people to do more. Appetite for volume in LFP [Longitudinal Family Physician payment model] is not there. There's no incentive to do more."

Proactive crisis management and contingency planning

Working proactively with teams to prevent crises, address challenges, plan for coverage and increased workloads, and establish clear crisis management protocols.

"Our teams are in survival mode. How do we make it to next year? Our imaging is stuck in survival. Take a step back and look at the big picture 5-year plan."

Reimagining team structures and roles

Redistributing workloads by integrating interprofessional team members, e.g., RNs, NPs, RMs, optimizing the scope of each role, and clarifying each role's responsibilities to maintain safe, sustainable care.

"There are many FPs that used to do maternity care – how to leverage skills that may not be intrapartum skills to offload those that are delivering babies? Pairing with someone who is doing the delivery."

Building a foundation for sustainable collaboration

Creating formal team agreements, describing shared values, and implementing robust onboarding, mentoring, and education to build trust, ensure continuity, and remain adaptable.

"How can we support groups in a different way to address provider shortages by using resources that we have to ensure safe, sustainable maternity care?"

Critical conversations involving key system partners and frontline providers should centre on making collaboration easier and more sustainable by addressing funding models and human resource shortages while supporting equity, well-being, and proactive crisis management.

Partners are encouraged to allocate time, compensation, and space for these discussions to ensure all voices, including OB-GYNs, shape sustainable solutions. Conversation enablers include fair pay for providers' time (away from patients), ample meeting notice, and engaging Indigenous partners and people with lived experience where possible.

"Providers need system partners to hear their ideas and action suggested improvements."

Recommended joint actions for senior leaders to advance critical conversations

- Participate in perinatal leadership meetings and the Perinatal Community of Practice Steering Committee (CoP) to gather input and collaborate on practical solutions for safe, sustainable team-based maternity care. Discussion points could include funding and professional challenges to teamwork, as well as strengthening recruitment efforts with support from health authorities.
- Invite Perinatal CoP Steering Committee co-chairs and designated members to participate in Ministry and health authority meetings on perinatal issues related to or impacting team-based care.
- Ensure the Perinatal CoP has a seat at every JCC table—whether it's the Family Practices Services Committee (FPSC), Shared Care Committee (SCC), Joint Standing Committee on Rural Issues (JSC), or Specialist Services Committee (SSC) —where planning for maternity and newborn care takes place. This also applies to any meetings focused on analyzing, assessing, and spreading maternity care projects.
- Support regional team development by funding quality coaching, e.g., RCCbc, and facilitating Primary and Community Care (PACC) and team mapping to identify opportunities, clarify roles, leverage current skills and expand supports for rural and urban communities. Include Divisions of Family Practice, Medical Staff Associations-Facility Engagement Societies, and Primary Care Networks.
- Create and/or share resource guides that detail best practices and tools for collaborative care models, ensuring every professional has up-to-date information and support.
- Foster and support mentorship and peer support initiatives, pairing experienced providers with those new to maternity care to build capacity and confidence.

Breakout #2: learning and recruitment

Maternity care is a cornerstone of comprehensive health care, requiring a well-prepared and engaged workforce to ensure high-quality patient outcomes. The education and training of future maternity-care providers play a critical role in maintaining and strengthening this workforce. Dr Maria Hubinette presented on the SFU School of Medicine's approach to building a collaborative model for clinical learning and posed discussion questions to explore what learning experiences will inspire primary care providers to pursue maternity care. The following themes highlight factors that members felt currently influence medical students' and residents' interest in maternity care careers.

Opportunities

Positive learning culture

Supportive learning environments with positive mentors inspire learners and improve experiences. Positive role-modelling and systems that encourage asking for help build resilience and confidence. Structured and balanced clinical experiences with realistic expectations promote effective learning.

Collaborative models of care

Team-based, interprofessional approaches and exposure to new models of care—like integrating midwifery, social work, and telemedicine—enhance learning. Normalizing learners' involvement in effective teams and hands-on practice is key to developing and retaining skills. Showing collaborative problem-solving through a buddy or team system can motivate learners by fostering strong professional relationships.

"New grads want support and not to work alone."

Community involvement and longitudinal practice

Maternity care can be quite segregated. Involving learners in community-level obstetrics and longitudinal relational care, including exposure to early prenatal care and intrapartum care across settings, fosters belonging, commitment, and professional identity. Normalizing learners' involvement in community-based, longitudinal care and supporting hands-on practice are essential for skill development, competence, confidence and retention. Exposure to diverse practice settings, including rural and smaller sites, contributes to a more comprehensive and meaningful learning experience.

"Larger sites get a bulk of residents. How can we ensure other sites get placements?"

Financial incentives

Financial incentives and maternity-focused professional development may increase new graduate engagement. Maternity Care for BC (MC4BC) is one FPSC incentive program; expanding incentives could further increase interest. The current payment model lags other programs, such as the hospitalist program.

Barriers

High-pressure clinical settings, including long hours and demanding on-call schedules, e.g., 24-hour rotations, lead to negative perceptions and are major disincentives. Many members noted that maternity rotations can often feel chaotic.

- Maternity care landscape: Perinatal professional shortages, service diversions, and distressed, burnt-out teams reduce preceptors' capacity and diminish interest in maternity care careers.
- Insufficient support systems: Both emotional and operational for learners and providers; can deter learners from pursuing maternity care, especially during a time of unprecedented strain on the system. Learning spots cannot simply be expanded; they need to be supported.
- Physical space constraints are significant obstacles to effective mentorship and positive learner experiences. The lack of dedicated spaces for teaching and mentorship, especially in high-demand facilities, limits opportunities for practical experience and collaborative learning.

- Financial disincentives, pay inequities, and limited access to incentives for maternity care roles undermine interest in maternity care careers. New graduates often perceive alternative positions as less risky and more financially attractive.
- Fragmented curriculum and educational experiences across sites and health authorities, ranging from limited exposure to certain care areas to missed opportunities for exposure to normal, community-based, and longitudinal maternity care, and a lack of standardized education models, highlight areas that need policy and institutional support for effective maternity care training.

"Hospitalist contracts are more enticing, which include sign-on bonuses and loan forgiveness. Current payment models are not comparable."

Recommended joint actions

To encourage careers in maternity care, health care providers and system partners can work together to create supportive learning environments that foster a sense of belonging. System partners—including medical schools—can advocate for policy changes, support curriculum innovation, provide necessary resources, and promote interdisciplinary care models. Collaborative efforts can engage learners, drive lasting commitment to maternity care, and support workforce sustainability and quality across the province. The following recommended actions can be considered to promote learning and recruitment:

- **Promote community and longitudinal practice:** Create pathways for learners to participate in community-based and longitudinal obstetrics, including placements in smaller sites and rural communities. Support interprofessional collaboration and exposure to innovative care models.
- **Engage in dialogue with the SFU Medical School leadership**: discuss ideas to support longitudinal maternity primary care in family practice learning across practice settings, e.g., clinic, emergency room, to influence residents' interest in maternity care and women's health. This includes supporting OB rotations and pairing learners with perinatal teams that enjoy their work, function well, and promote positive aspects of maternity care.
- **Strengthen administrative and policy support:** Develop clear policies that foster student learning and ensure access to maternity care experiences; facilitate learner integration; support preceptors; and address curriculum gaps—particularly in women's health, abortion care, and mental health support.
- **Standardize and integrate curriculum content**: Work towards consistent educational experiences across health authorities, ensuring core competencies include exposure to the full spectrum of maternity care (including normal births, acute care, and reproductive health).
- **Enhance physical and operational infrastructure**: Invest in dedicated teaching spaces, resource allocation, and stable contracts for maternity care providers, particularly in under-resourced and rural settings.
- **Foster a positive, supportive learning culture**: Prioritize role modelling, mentorship, implement buddy systems, and provide structured debriefing and team-building opportunities to mitigate stress/trauma and build confidence.
- **Address financial and systemic disincentives**: Advocate for equitable compensation models, targeted financial incentives, and policies that recognize the unique demands of maternity care. Ensure transparency and fairness in pay structures.

"Let students flow with their patients through the entire journey and all team members experience the whole pathway."

Breakout #3: system alignment, spread and sustainability

The Shared Care pregnancy and newborn care team, along with Perinatal Services BC (PSBC), presented on their joint efforts to build alignment towards an integrated approach to advancing perinatal care across BC to better support providers and patients. PSBC presented key elements of their current strategy and future direction.

Following this, a panel discussion brought together four successful team-based care projects to reflect on successes, lessons learned, and ideas for spread and sustainability. Projects included the Birth Related Cardiovascular Health (BiRCH) Initiative, Maternity Care Strategy Initiative in the Interior Region, Maternity Services at Bulkley Valley Regional District Initiative, and the Huckelberry Midwives Initiative.

Key considerations for aligned perinatal services across BC

Participants gave feedback on proposed workforce planning initiatives and sustaining successful initiatives. They pinpointed existing gaps, shared successful strategies for spread, and discussed factors that could help or hinder putting these actions into practice.

Recurring themes across all breakout discussions included cultural safety, funding and payment models, team-based care, retention and recruitment, and adequate resource allocation. Members stressed that meaningful planning and engagement must include OB/GYN colleagues, who were absent from the strategies presented. This engagement is critical, given that a large percentage of patients require hands-on OB care. This section provides a detailed summary of discussions.

Cultural safety and equity

Persistent concerns exist around rural and remote access and the lack of culturally safe services, especially for Indigenous populations. Scaling up community-based outreach and telehealth initiatives can help to promote equity and accessibility. Lack of prioritization for Indigenous Peoples disrupts access and care continuity, and defensive medicine continues to impede trauma-informed, patient-centred care.

Addressing the needs of Indigenous communities, supporting informed choice, and ensuring culturally safe practices are vital. This includes advocating for regional birthing centers to reduce patient relocation. Calls to challenge colonial policies, promote trauma-informed care, and foster safe organizational spaces reflect a broader commitment to equity.

"Our Indigenous community faces colonial policies and surveillance, social/economic gaps, complex trauma (residential school survivors), birth evacuees."

Funding and payment models

Misaligned compensation and billing differences create interprofessional tension. Current payment models, including the Longitudinal Family Physician (LFP) and fee-for-service (FFS) models, do not align well with antenatal and postpartum care and can be counterproductive. Collaborative care requires better incentives and a consistent funding model. Expanding care models to provide more patient time without disrupting continuous nursing roles and equipping nurses and nurse practitioners to embed perinatal care into their practices are essential.

Members shared that the LFP model doesn't provide sufficient incentives for early pregnancy care, as 30-minute appointments aren't enough to encourage engagement or keep up with updates. Family physicians doing hospital work do not have incentives to do this work, whereas health authority-hired hospitalists have resources to support their roles. Midwives have support for overhead, whereas family physicians do not. Further, resources like the Medical On-Call Availability Program (MOCAP) resources are shared across multiple communities, and current funding is insufficient for on-call availability. Members also shared that the work of OBGYN is highly valued and critical, but most communities are not doing primary care OB.

"Most locums bill LFP and new physicians do, but for FPs providing intrapartum care, it's often a pay cut."

Further, many midwives are shifting focus to post-partum care due to the payment structure, which impacts overall service capacity. Members shared that approximately half of midwives practice full scope, with many shifting their focus to postpartum care due to the current funding model.

"Some midwives are delivering fewer babies due to the payment structure for their services. As post-partum care is incentivized equally, if not better than, deliveries and intra-partum care, more midwives are focusing solely on post-partum care, contributing to a lack of pregnancy and newborn care capacity in BC." *—Midwife participant*

Insufficient funding for interdisciplinary and team-based models, infrastructure, and leadership roles was a recurring concern. Inflexible payment structures and reluctance to innovate in financial models present ongoing challenges. Models that do not incentivize one aspect of care over another, e.g., postpartum vs. delivery and parallel use of longitudinal fee-for-service and alternative payment plans. Equitable payments, capital for infrastructure, and dedicated leadership funding were highlighted as essential.

"Providing a menu rather than a model will enable each region to look at particular needs and be nimble."

Team-based, interprofessional care, and health human resources

Effective, well-funded team-based models were viewed as critical for reducing burnout and improving outcomes. Shared roles, defined responsibilities, and incentives for teams handling complex cases or supporting refugees and new immigrants were recommended. Coordination, support, and protected time for team building and team agreements were commonly cited.

High attrition rates, inadequate support for new practitioners, and limited mentorship opportunities undermine workforce sustainability. Early specialization requirements and lack of exposure to maternity care during training were highlighted as barriers.

Early exposure to maternity care in training, role modelling and mentorship for new practitioners, and opportunities for professional upskilling were identified as important for retention and recruitment. Members noted that preventive rather than reactive approaches to team-based care are needed, especially for fragile teams within the systems.

"Recognizing critical interdependencies between professional associations, system partners, and services is key."

Interdisciplinary teamwork was noted as essential to sustaining maternity care, and improved communication infrastructure, system integration, and shared leadership are necessary enablers.

Applying approaches from successful interdisciplinary clinics and collaborative programs was highlighted as an effective strategy. Colleges should advocate more for interprofessional recognition.

Members also noted that flexible workforce arrangements are needed to address gaps in the current system. The lack of mechanisms to support adaptable roles, including the involvement of semi-retired or part-time professionals in maternity care, limits workforce flexibility and retention. Integration of diverse professionals, including midwives and family physicians, is encouraged to improve coverage. Blended payment models allowing simultaneous participation in LFP and fee-for-service arrangements are enablers.

"We need more bodies. We're not going to recruit if OB work is less appealing than comparable work."

Nurse satisfaction and retention remain a challenge due to reduced schedule flexibility and increased reliance on expensive agency nurses, especially in rural clinics where capacity is limited, and health authority support is needed.

"We need to provide flexibility to our nursing cohorts (i.e. flexibility in rotations and shifts)."

Providers emphasize the importance of seamless care transitions across all stages of maternity care, particularly post-partum follow-up. Formalized care pathways and addressing gaps in post-partum support are needed to improve patient experiences.

Infrastructure, engagement, and administrative support

Fragmented privileging processes, restrictive scopes of practice, and complex credentialing requirements were seen as significant burdens. Siloed budgets and a lack of centralized systems increase administrative load and hinder professional mobility. Strained relationships with health authorities, difficulties in collaboration, and lack of engagement from Divisions of Family Practice or leadership were cited as barriers to coordinated action.

Poor interoperability of electronic medical records, insufficient data tracking of long-term maternal outcomes, and insufficient business planning tools for communities limit informed decision-making and system improvement. Further, lengthy and complex credentialing processes at health authorities hinder professional mobility and timely coverage, especially for international medical graduates or trained professionals. Provincial credentialing is needed to allow for mobility throughout the province. Members noted that the provincial credentialing and privileging system CACTUS model was intended to address licensing issues, but it hasn't been effective due to other challenges, particularly in facilities.

"Credentialling takes too long. There have been some strides, but overall, clearing the path for international medical graduates, particularly those coming from the US, still takes too much time and effort."

Centralized privileging systems, accessible qualification databases, and ongoing medical and system partner leadership support were proposed to streamline administrative processes and reduce redundancy. Infrastructure and technology to support professional engagement and interoperability of patient records were also emphasized.

Resource allocation

Funding, staff, and facilities are often unevenly distributed, with rural or remote areas particularly affected. Limited investment in these communities worsens access issues. Improved infrastructure, staffing, and collaboration between health authorities—especially in isolated regions—are essential, as many rural communities span multiple health authority boundaries and are hours from major centres. Targeted investment and infrastructure support can help close the gaps.

Collaboration among regional partners is crucial for improving perinatal care, as smaller communities often navigate barriers more effectively and can offer cost-saving solutions to the Ministry for systemic change, though contract inequities persist.

"Expanding NP involvement could help support maternity care, especially in community settings where some funding models exist."

Leveraging data for meaningful system change

While the value of community and site-level professional surveys in informing care models is acknowledged, meaningful engagement and transparent follow-up are essential for driving real change. Simple surveying may not fully capture the complexities or contributors to burnout, and deeper mapping processes are recommended. Members noted that current data gaps include:

- Evaluation frameworks to support quality improvement, workforce planning, and investigation of service disruptions
- Baseline data identifying what professions are performing which perinatal services, in which communities/sites, and for what patient populations and volumes, to monitor and assess impact
- Integrated data systems for accurate projections of birthing room needs and patient pathways, number of providers for shift coverage based on patient volume, and tracking for long-term maternal outcomes
- Systematic process for gathering data on why family physicians and registered midwives leave obstetric and intrapartum care, as well as nursing retention

Further, participants noted that when providers are asked to participate in surveys to share their experiences, it is critical that the resulting actions and next steps are shared back.

Spreading successful innovation

Community innovation, exemplified by the BiRCH clinic, demonstrates the value of engaging the right people and fostering trust, but frustration arises when effective models lack the backing of health authorities. Members noted that system partners should work with providers to facilitate regular sharing of best practices, challenges, and solutions; and to create tailored resources and ongoing support to help teams apply new strategies.

With established clear metrics and review cycles to evaluate initiatives and adapt as needed, encouraging team autonomy to innovate and scale successful practices across the network is key. Members noted the importance of understanding that spread is not always a shortcut to implementation and still requires reviewing a successful model or idea and making adjustments for a new area, community, and context, all of which still require resourcing and support.

"Leveraging small amounts of funding and resources that are available is important- micro changes build and add into larger areas of change."

Recommended joint actions

Challenges in establishing a sustainable maternity care workforce and sustaining successful initiatives can be addressed through targeted strategies focused on cultural safety, funding and payment models, collaborative team-based care, retention and recruitment, and resource allocation. System partners play a key role in supporting and working with providers to advance these efforts. The recommended actions from Breakout #3 are grouped below by theme. Additionally, ideas for spreading successful initiatives, resources, and approaches are listed throughout, a comprehensive list is included in Appendix A.

Prioritize cultural safety and Indigenous engagement

Supporting trauma-informed, culturally safe practices and challenging colonial policies are vital for equitable care to Indigenous communities:

- Support providers and teams to embed cultural safety and trauma-informed care into practice
- Promote learning sessions on serving Indigenous populations through Indigenous storytelling, human connection, experiential learning, and team conversation
- Advocate for regional birthing centers to reduce patient relocation

Support interdisciplinary collaboration and team-based care

- Fund peer support, role modelling and mentoring within teams to build professional confidence.
- Promote practice supports, e.g., models, guides, tools, digital referrals, to support seamless care.
- Give each community the resources to implement their own team-based care models and strategies based on a provincial framework, working collaboratively with Primary Care Networks, Divisions, and Medical Staff Associations.
- Ensure support and funding are available for teams to have dedicated medical leads.
- Create a roadmap of funding and supports for teams, e.g., Divisions, PSP, and shared team-based care templates for achieving full scope with flexibility to work in practical capabilities
- Support EMR interoperability to ease collaboration.

Create balanced and flexible funding and payment models

- Modernize funding models to reflect the complexity and time commitment required in maternity care, with an emphasis on equity across regions and professions, with a focus on equitable incentives for teams serving high-complexity populations or clients
- Future-proof contracts that adapt to demographic and geographic shifts and explore patient-based funding models that follow the patient
- Explore compensation models to encourage midwives to provide intrapartum care and flexibility in nurses' rotations and shifts
- Streamline credentialing and privileging processes to facilitate timely coverage and workforce integration

Enhance retention and recruitment strategies

- Promote mental health and peer support resources focused on burnout prevention and moral injury to ensure the well-being of maternity care professionals, especially those navigating extreme challenges in their communities.
- Provide funding, tools, and support for mentorship within the community and across systems, including new-to-practice groups, e.g., billing/guides and tips, and managing work/life balance.
- Offer equitable recruitment incentives, such as commitment bonuses and housing support, and co-create a centralized locum pool with adequate incentives.
- Develop incentives to work in obstetrics and join struggling communities across the province
- Support LFPs to provide early pregnancy care and routine post-partum care.
- Explore how to increase the number of community health workers to support newcomers to Canada

Enhance education and training

- Enhance the training of new colleagues in maternity care and support learner and professional involvement in team education
- Support midwives to take on more complex, yet low-mid risk patients and develop enhanced midwives' education, e.g., C-section assisting, prescribing training.
- Fund and support the training of community FPs to provide antenatal and post-partum care.
- Identify and train nurses and other providers to include stronger perinatal care in their practice.

Leverage data to inform models of care

- Developing evaluation frameworks to support quality improvement, workforce planning, and investigation of service disruptions is imperative
- Integrated data systems for accurate projections of birthing room needs and patient pathways, estimated number of providers needed for shift coverages based on patient volume, and long-term maternal outcomes
- Provide clear connection between survey completion, resulting action, and impacts back to providers

CLOSING

The themes and challenges identified throughout this report emphasize the importance of centering the voices of perinatal care professionals in building sustainable maternity care across the province. The priorities of cultural safety and trauma-informed care, team-based care, funding and payment models, retention and recruitment, and resource allocation were consistently identified as areas of improvement within the perinatal care system. The recommended actions throughout the report rely on collaboration across the system and on individual dedication to move forward.

In response to the report findings and to align with the specific challenges within this system priority, the Perinatal CoP Steering Committee has centred the 2026-28 Strategic Plan on these themes and recommendations. The Shared Care Pregnancy and Newborn Care Portfolio has also incorporated these

themes into its strategic framework, ensuring alignment across the JCCs in addressing this system priority.

This report would not have been possible without the dedication, expertise, and openness of the hundreds of individuals who contributed their time and perspectives, both at the November 2025 event and in ongoing CoP engagements. We extend our gratitude to every individual who shared their experiences, identified challenges, and offered thoughtful suggestions in an unwavering commitment to improving pregnancy and newborn care across the province.

Acknowledgments

Perinatal Community of Practice Steering Committee & Planning Committee Members

Name	Role in CoP	Clinical Role
Shelley Ross	Co-Chair & Steering Committee Member	Family Physician
Julie Wood	Co-Chair & Steering Committee Member	OB/GYN
Brenda Wagner	Steering Committee Member	OB/GYN
Tia Felix Keisha Charnley (incoming)	Steering Committee Members	Midwife, Co-Chair of Indigenous Midwives Advisory Council Representative
Marianne Morgan	Steering Committee Member	Family Physician, Perinatal Services of BC Representative
Rhonda Stephens	Steering Committee Member	Midwife, Midwives Association of BC Representative
Erik Swartz	Steering Committee Member	Pediatrician Representative
Alicia Power	Steering Committee Member	Family Physician, Shared Care Committee Representative
Magda Steenkamp	Steering Committee Member	Family Physician, Family Practice Services Committee Representative

Erica Phelps	Steering Committee Member	OB/GYN, Specialist Services Committee Representative
Hayley Bos	Incoming Co-Chair	OB/GYN
Kathleen Ross	Incoming Co-Chair	Family Physician
Amy Sawchuk	Steering Committee Member (Incoming)	Family Physician Joint Standing Committee on Rural Issues Representative
Annabelle Sproule	Planning Committee Member	Midwife
Nagu Atmuri	Planning Committee Member	Family Physician

Forum presenters: Welcome and opening remarks:

Dr Shelley Ross & Dr Julie Wood (CoP Co-Chairs & event emcees)

Elder Syexwáliya Ann Whonnock

The Honourable Josie Osborne, MLA

Dr Charlene Lui, President of Doctors of BC

Forum presenters: Session Leads/Facilitators

Dr Cecile Andreas, physician leadership coach

Dr Maria Hubinette, associate dean, Education, SFU School of Medicine

Rob Finch, executive director, Perinatal Services BC

Dr Marianne Morgan, Perinatal Services BC

Brooke Knowlton, senior manager, Strategic Initiatives, Doctors of BC/JCC

Dr Alicia Power, SCC representative and CoP Steering Committee member

Dr Jennifer Kask, Birth Related Cardiovascular Health (BiRCH) Clinic

Dr Shaun Davis, Maternity Care in the Interior Region

Dr Melanie Todd, Maternity Care in the Interior Region

Dr Sheila Smith, Maternity Services at Bulkley Valley District Hospital

Keisha Amanda Charnley, Huckleberry Midwives

Cello Lukey, Huckleberry Midwives

Forum planning and report development consultant

Jennifer Scrubb, Jennifer Scrubb Consulting Inc.

APPENDIX A

Effective strategies with potential for spread

Team-based care (TBC) models

Successful regional interprofessional clinics, approaches, and resources to improve collaboration, efficiency, and patient outcomes have included:

- Early engagement of public health nurses in the perinatal journey
- JCC-funded maternity care projects
- Networking funds from ROAM—spread to urban communities
- OBs providing 3+ months of rural service
- PCN Hub—resources, payment models, team agreements, learning
- Real Time Virtual Supports (RTVS)—with equitable funding—expand to urban communities
- TBC templates for learning—including for small site collaboration across initiatives (MSA-Facility Engagement, Divisions, JCC projects)

Continuing Professional Development

Programs supporting early-career, interdisciplinary, and transitioning providers to help address recruitment and retention challenges:

- Cultural safety, harm reduction-trauma informed care learning sessions
- Effective training models for providers new to maternity care
- Nurse in practice
- Re-entry positions for residencies
- Residents providing maternity care
- Subspecialties to do a fellowship—RTS

Patient education models

- Best Beginnings model – promote wider adoption
- Pregnancy and Parent Learning Centre (PSBC) – spread awareness
- SmartParent

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