

Supporting Local Collaborative Models for Sustainable Maternity Care in British Columbia



*Recommendations from the
Maternity Care Enhancement Project*

December 2004

Executive Summary

This report represents the efforts of an extensive consultation and research process to address the sustainability of maternity care services in British Columbia. It arose from the 2004 Working Agreement between the British Columbia Medical Association (BCMA) and the Ministry of Health Services (MOHS) calling for the development of a practice and business model to encourage physicians to provide maternity care services.

Through an extensive consultation process, stakeholders pointed to the need to develop collaborative models of care, recognizing that only by working together can we find solutions to the health human resources crisis currently facing the maternity care system. While this report offers specific recommendations with regards to physician reimbursement to value the obstetrical care provided by those practitioners who currently provide more than 50 per cent of the primary maternity care services in this province, the message from stakeholders was clear: sustainable maternity care is about more than money. The spirit of the MCEP process and report highlights the fact that maternity care is founded on an interdependent system of caregivers from a variety of disciplines who together provide high quality maternity services. This report offers recommendations to support a range of providers and encourages the development of collaborative care models that value and respect the specialized skills each provider brings to the delivery of maternity care.

This desire to work towards integrated models of care is hinged on the recognition that maternity services must be appropriately flexible to meet the needs of the people, resources and geography of British Columbia. This report recommends proposals to bolster the abilities of local communities to sustain their own models of care, outlining opportunities for health authorities to support the development of quality, accessible maternity care.

Finally, the process was seen as a chance to begin the work of developing a women-centered approach to maternity care services, where the mother and her baby are placed at the centre of care and services are planned and provided to meet their needs. This approach means that maternity care service requirements must drive the workforce requirements. This report takes the first step down this path by offering a set of guiding principles that provide a philosophical,

women-centered approach to inform local maternity service strategies.

Participants in the MCEP consultation process see this report as the beginning of a longer process of reform regarding BC's maternity care system. There is an appetite among stakeholders for more discussion and work to take place than was possible in the time frame and mandate of this project. Recommendations in this report point to the need for further work be undertaken to develop a truly integrated, collaborative and sustainable framework for maternity care in this province.

Maternity Care Enhancement Project Recommendations

Recommendation #1

The Ministry of Health Services support the development of a women-centered maternity care pathway for British Columbia.

Recommendation #2

The Ministry of Health Services promote and support women-centered, collaborative, team-based service models among all maternity care providers.

Recommendation #3

The Ministry of Health Services and stakeholders extend current strategies to sustain practitioners and examine long term strategies to enhance collaborative care

Recommendation #4

Health Authorities support the implementation of collaborative models of maternity care at the regional and local level.

Recommendation #5

The Ministry of Health Services supports the development of a coordinated, comprehensive provincial maternity education plan for all maternity care providers at undergraduate, graduate and continuing education levels.

Recommendation #6

The Ministry of Health Services commit to a provincial approach to support quality in maternity care services that includes the formation of formal collaboratives among providers and the review of mortality and morbidity outcomes.

Recommendation #7

The Ministry of Health Services establish a process to monitor and ensure the progress and implementation of the recommendations in this report.

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Introduction: The Maternity Care Enhancement Project

The Maternity Care Enhancement Project (MCEP) was a strategic process to address the sustainability of maternity care services in British Columbia. It arose from the 2004 Working Agreement between the British Columbia Medical Association (BCMA) and the Ministry of Health Services (MOHS). The Working Agreement articulated a commitment to establish a working group of stakeholders charged with developing a “practice and business model in support of a (this) continuous maternity care quality strategy” by November 30, 2004.¹

The mandate set out for MCEP was to develop a strategy to address sustainability issues for physicians to encourage them to initiate or continue to provide maternity care services through the development of a practice model that fosters a supportive working environment. An extensive consultation and research process was undertaken, resulting in a broad base of support for collaborative models of maternity care practice. This report outlines the role collaborative care models can play in supporting the sustainability of maternity care services. It also offers recommendations regarding how to provide physicians with adequate reimbursement to value their obstetrical work while promoting shared care.

However, through MCEP’s consultations with stakeholders, there was a clear message that sustainable models of maternity care in this province must include the sustainability of all maternity care providers, recognizing that maternity care is founded on an interdependent system of caregivers from a variety of disciplines who together provide women and their families with high quality, effective

¹ Other processes and commitments in different sections of the 2004 Working Agreement focused on the development of short term strategies to support family physicians currently providing obstetrical services and to encourage other physicians to provide these services. One time funds of \$2 million dollars were directed to this purpose and resulted in the establishment of the short-term Service Enhancement Fee.

maternity care services. This report offers recommendations to foster sustainable models of maternity care that support a range of providers from nurses, midwives, family physicians, GP surgeons, GP anaesthetists, obstetricians, maternal fetal medicine specialists, neonatologists, pediatricians and other ancillary providers including sonographers and doulas.

The MCEP process also offered an opportunity to examine and reflect on the various maternity care needs and resources of local communities, recognizing that maternity services must be appropriately flexible to meet the needs of the people and geography of British Columbia, whether those services are situated in Fort Nelson, Kamloops or Vancouver. Stakeholders stated that a “one-size fits all” practice model would not work for all communities. To be sustainable, maternity care models need to offer flexibility to create local solutions while respecting local capacity and reflecting local resources. This report puts forth recommendations to bolster the abilities of local communities to support and sustain their own models of maternity care, outlining where health authorities are accountable to support the development of quality, accessible maternity care.

Finally, the process was a chance to begin the work of developing a women-centered approach to maternity care services, where the mother and her baby are placed at the centre of care and services are planned and provided to meet their needs. This report takes the first step down this path by offering a set of guiding principles that provide a philosophical approach to inform local maternity service strategies. Each recommendation in this report complies with the principles, which set out clear and consistent themes to establish woman -centered maternity care services.

Maternity care services should offer flexibility for local solutions while respecting local capacity and reflecting local resources.



The Consultation Process: Reaching Out to Women and Providers

In order to achieve the ambitious goal set out by the 2004 Working Agreement to develop a practice model for sustainable maternity care by November 30, 2004, BC Women's Hospital & Health Centre was asked by MOHS to lead and facilitate a consultation and research process and develop a final report of recommendations.

2a. Ad Hoc Committee

The consultation process, chaired by Dr. Elizabeth Whynot, President of BC Women's Hospital & Health Centre, was lead by the MCEP Ad Hoc Committee made up of stakeholders from key organizations such as the Department of Family Practice at BC Women's, representatives from BC Reproductive Care Program (BCRCP) and a research team provided by the BC Centre of Excellence for Women's Health (BCCEWH). This committee formed the core project team and worked to chart the project's path, come to conclusions on the process and delineate the contents of the final report.

A Project Charter was developed to guide the process and the research team, provided by BCCEWH, ensured the consultation process and final report was evidence-based. Data gathering methods included document and literature reviews, along with surveys and interviews with stakeholders, including consumers and providers.

2b. Working Group

A broad-based, multidisciplinary Working Group was established to encourage wide participation and input on maternity care services in BC. It was formed through the solicitation of stakeholders identified in the Working Agreement. The Working Group included representatives from the British Columbia Medical Association (BCMA), MOHS, BCRCP, the College of Physicians and Surgeons, Society of General Practitioners of BC (SGP), Registered Nurses Association of BC (RNABC), the College of Midwives of BC (CMBC) and providers and administrators from each health authority.

The Working Group met for three sessions on October 22, November 5 and November 19, 2004, to discuss issues of concern and provide input towards the creation of a framework and practice models for maternity care services in B.C. Prior to each session, participants were given pre-reading material focusing on key maternity care topics, from education and human resource issues to reimbursement challenges, in order to inform the discussions. Information for the briefs was gathered from data and research on maternity care synthesized for the Working Group by the research team. Access to each session was facilitated by videoconference technology, with each health authority offering representatives a choice of two sites from which to participate. The sessions, chaired by Dr. Elizabeth Whynot, were governed by an external facilitator in order to ensure all participants had an opportunity to provide input in an efficient and effective manner.

The Working Group identified a number of themes that have informed the recommendations in this report. These themes included the need to promote and support collaborative, integrated care among all maternity care providers; the need to support educational initiatives for all providers at the undergraduate, graduate and continuing education level; the need to allow for flexibility, the need to support locally-based models of care that reflect local capacity and resources; and the need to value the work of maternity care providers by offering them adequate reimbursement.

2c. Provincial Women's Health Network

The Provincial Women's Health Network (PWHN) was established in the spring of 2004 with representatives from all health authorities and some community organizations. The PWHN was identified as a resource to the MCEP process because its mandate is to support women's health and to seek ways to support the recently-released provincial women's health strategy described in *Advancing the Health of Women and Girls*. The PWHN was informed of the MCEP process at its fall meeting and invited to review the first draft of the guiding principles. A major recommendation from the group was that the MCEP adopt a women-centred approach to maternity care planning. Members were subsequently sent all the briefing materials prepared by the research team and circulated to the Working Group.

2d. Women's Input

It was important that the project be informed by women's perspectives. Consultation with women about their expectations

regarding maternity care took several different forms. Concurrent research investigating rural women's experiences of maternity care from communities such as Bella Bella, Alert Bay, Port McNeill, Port Hardy, Tofino, Old Massett and Queen Charlotte City, helped to inform the recommendations.

The majority of our information regarding women's maternity care needs came from literature reviews and satisfaction surveys. The literature depicts a growing consensus on what women want from the care that accompanies their experiences of pregnancy, birth and early mothering. Although uniquely defined by individual birthing women, the aggregate of these needs represented in the literature include: continuity of care, involvement in decision making, convenient access to services, satisfying relationships with care providers, choice within the experience of birth, feelings of being in control, and the presence of partners and family/social support.² It has been suggested that "unmet needs often lead to stress, anxiety and fear which in turn lead to a less positive birth experience".³

More research needs to be conducted on what women want from their maternity care services. However, we do know that what women value most is having a range of options from which to choose to meet their individual needs.

2e. Written Feedback

In addition to the inperson and videoconference meetings, stakeholders were invited to submit written feedback throughout the process to ensure that all voices and concerns were heard. The project received detailed feedback from a variety of stakeholders in the form of letters, emails and faxes that helped to inform the recommendations put forth in this report.

2f. Concurrent Activities

The MCEP consultation process was undertaken within the broader context of ongoing interactions between the MOHS and the BCMA towards sustaining access to high quality medical services in BC. These concurrent activities included discussions of the expansion of training capacity for all health professionals involved in maternity care (physicians, midwives and nurses especially), reconfiguration of primary care and hospital resources by health authorities, a variety of

² Grzybowski, S., & Kornelsen, J. (work in progress). What are the components of a sustainable rural maternity care system? Recommendations for policy and practice, September 2004.

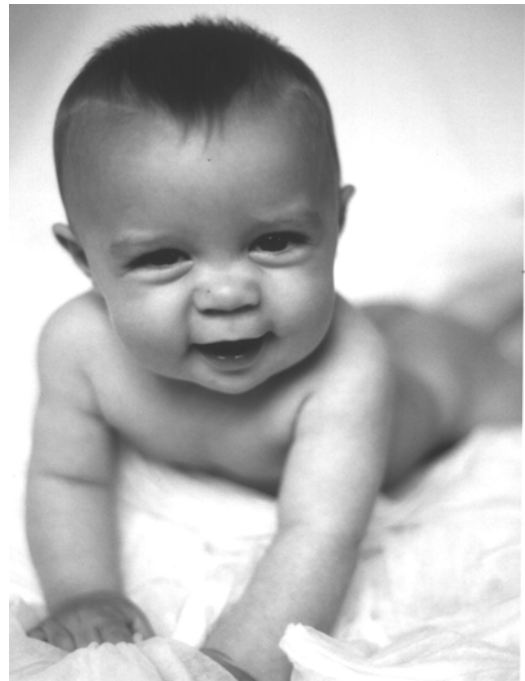
³ Ibid, 2004.

research activities addressing maternity care access, and provincial planning processes for Specialized Perinatal Services.

2g. Limitations to Consultation

Given the short-time frame, the consultation process was as extensive as possible under the remit of this project. In some cases, data were not available in time to inform the process. It was also challenging to reach out to all the stakeholders from every discipline involved in the provision of maternity care in the three month window of the project. However, the most difficult group from which to gain adequate input from was women and their families. The short time frame meant it was unrealistic to conduct focus groups or surveys across the province with women to gain their thoughts on BC's maternity care system. Instead, the consumer perspective in this report is informed from past and current research into women's views of maternity care services. This report acknowledges these limitations in information and data, and recommends further research be initiated to solicit broad-based input from all stakeholders into BC's delivery of maternity care services.

Maternity care is based on an interdependent system of caregivers who work together to provide women and their families with high quality care during pregnancy, childbirth and the postpartum period.



Setting the Context: The BC Picture

The geography and demography of British Columbia play an integral role in shaping the delivery of maternity care services to women and their families and setting the stage for the current challenges to sustainable maternity care.

3a. Geography

BC has a population of 4,196,383 million people⁴, however, the population is unevenly distributed as the majority of people reside in the southwestern portion of the province, mainly clustered around the Lower Mainland, the Okanagan and the southern tip of Vancouver Island. The rest of the province has a low population density with a widespread scattering of small and remote communities, including extremely small Aboriginal communities, throughout the eastern and northern regions where due to the terrain, severe weather conditions can impede on transportation and limit access to health services.

The delivery of maternity care services in BC must be examined against this diverse, geographical setting. Given the geographic challenges, it is difficult to ensure equity of access to acute maternity care services in rural and remote areas. Stakeholders participating in this process were forthright in suggesting that a realistic approach must be taken to provide women and their families with a women-centered service while in light of women's preferences, safety, the availability of providers and the availability of transportation for both routine and emergency situations in these diverse geographical conditions.

3b. Population and Birth Projections

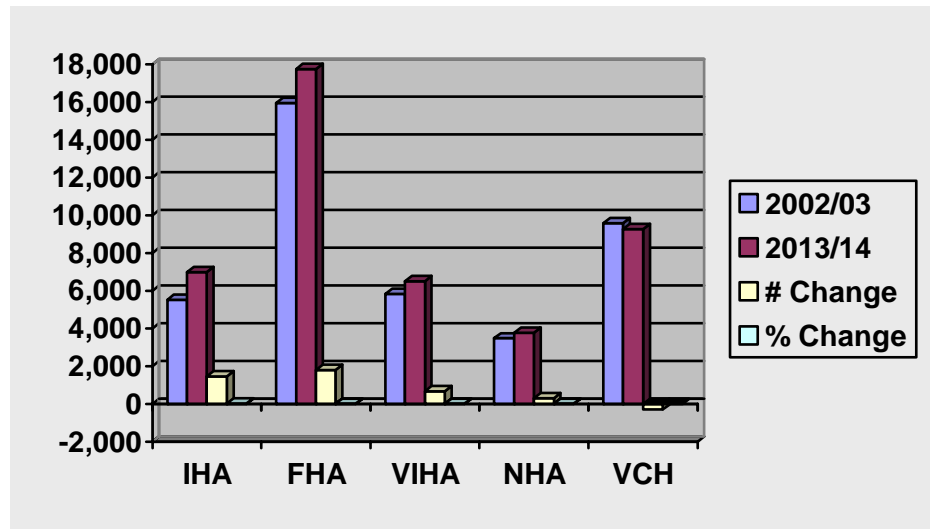
An analysis of population and birth trends in the province as well as an estimate of the number of births expected in each year by health authority region suggests that access to maternity care services, while challenging at present, will worsen without careful planning.

⁴ BC Stats, 2004: BC Quarterly Population, 1951-2004
(<http://www.bcstats.gov.bc.ca/data/pop/pop/BCQrtPop.htm>)

An analysis of population and birth trends in the past decade combined with projections for BC for the next ten years has important implications for the delivery of maternity care services in the future. Between 1995/96 and 1999/00, the number of births in BC dropped by 11 per cent from 46,853 to 41,667. This change occurred in the face of a five per cent increase in the total population of BC from 3,882,000 to 4,063,800 during the same time period. Both fertility and birth rates have decreased by 59.5 per cent and 61.2 per cent from 1952 to 2002 respectively.⁵

The latest figures show that in 2003/04, there were 40,278 births in BC.⁶ When examined by health authority, the highest number of births in 2002/03 were to women living in the Fraser Health Authority area (16,000), followed by Vancouver Coastal Health Authority (9,600), Vancouver Island Health Authority (5,800), Interior Health Authority (5,500) and Northern Health Authority (3,450).⁷ However, the number of births in B.C. is anticipated to level off in 2004/05 and then steadily increase every year thereafter. The projected number of births in 2013/14 is 44,280, representing a 10 per cent increase over 2003/04 births.⁸

Exhibit 1: Birth Estimates and Projections by Health Authority, 2002/03 – 2013/14⁹



⁵ BCRCPP. (2003) British Columbia Perinatal Database Registry: Annual Report 2003. Vancouver.

⁶ Ibid, 2004.

⁷ British Columbia Reproductive Care Program, 2004

⁸ British Columbia Reproductive Care Program, 2004

⁹ PHSA birth estimates have been integrated into the appropriate regional health authorities, based on the current number of women delivering at BC Women's Hospital and their respective regions of residence.

The increase in the number of births over the next decade is anticipated to be highest in FHA, but the proportion of increase is anticipated to be highest in IHA. The only health authority in which a decrease in the number of births is anticipated is VCHA. With the overall number of pregnancies expected to increase, there will be a concomitant increase in demand for maternity care services and in the workload of providers.

3c. Escalating Provider Workload Trends

In addition to the rise in the number of births expected, there are other important trends expected to occur over the next decade that will affect the workload of maternity care providers. For example, the last ten years have witnessed an escalation in the use of technological and pharmacological interventions during pregnancy and labour.¹⁰ The use of epidural anaesthesia, fetal monitoring, ultrasound and caesarean section are all on the increase. BC Women's has seen its caesarean section rate steadily increase from 21.9 per cent in 1994/95 to 29.1 per cent in 2003/04.¹¹ This escalation in technological interventions in birth is predicted to increase further and will result in an increase in provider workload.

Another important trend that is expected to continue to increase the maternity care workload is the steady increase in maternal age at first birth. The number of women over the age of 35 having babies in BC increased from 12.8 per cent in 1993 to 20.1 per cent in 2003.¹² Older maternal age is associated with increased maternal risk, infertility, complications of pregnancy and an increased risk of adverse outcomes, including stillbirths and congenital anomalies.¹³

The varied ethnic make-up of BC's population is also placing increased demands on maternity care providers for a variety of reasons, including barriers to care posed by language and cultural differences. For example, according to the 2001 census, 24.6 per cent of British Columbians speak English as a second language.¹⁴

¹⁰ Spitzer, Matthew. (1995) *Birth Centers, Economy, Safety and Empowerment*. J Nurse-Midwifery. July/August. 40(4):371-375.

¹¹ BC Women's Hospital statistics, 2004.

¹² BC Vital Statistics. *Birth-Related Statistics*. 2004.

¹³ Saed M. Ziadeh. (2002) *Maternal and Perinatal Outcome in Nulliparous Women Aged 35 and Older*. Gynecologic and Obstetric Investigation .54:6-10.

Jacobsson B, Ladfors L, Milsom I. (2004). Advanced maternal age and adverse perinatal outcome. *Obstet Gynecol*. 104(4):727-33.

¹⁴ Statistics Canada (2001): Population by mother tongue, by provinces and territories (2001 Census). www.statcan.ca/english/Pgdb/demo11c.htm.

Providers are also faced with trying to care for women with lives characterized by poverty, hunger, unstable living conditions, histories of violence and substance misuse.¹⁵ It is difficult to estimate the number of pregnant, substance-using women due to their reluctance to seek care, among other factors, however it has been estimated that in the Lower Mainland, an overall prevalence rate of 5.5 to six per cent of pregnancies have substance misuse as a risk factor.¹⁶ These women have an increased likelihood of having a low birth weight baby and these babies are at risk for a variety of health problems.¹⁷

3d. The Demographics of BC's Maternity Care Providers

There is a host of care providers involved in the delivery of maternity care. This section briefly reviews the role and demographic issues facing each provider.

Family Physicians

Family Physicians (FPs)¹⁸ are the main providers of care to women in BC throughout pregnancy, childbirth and the postnatal period. They provide clinical care in both community and acute care settings for women with low risk pregnancies and have a significant role in providing health education and counseling to support women and their families during the transition from pregnancy to parenthood.

Family Physicians may work in solo practices or in various forms of group practice. However, current models of solo practitioner maternity care by physicians are no longer sustainable, as evidenced by the high attrition rate of FPs providing obstetrical services. Of the 40,278 births in BC in 2003/04, approximately 51 per cent of those babies were delivered by Family Physicians (FP), 41 per cent by Obstetricians (OB), 4 per cent by Registered Midwives and 4 per cent by other practitioners.¹⁹ This marks a significant decrease in number of FPs delivering babies in the last 13 years. In 1991/92, 72 per cent

¹⁵ Poole N.(2000). Evaluation Report of the Sheway Project for high-risk pregnant and parenting women. British Columbia Centre of Excellence for Women's Health.

¹⁶ Legare, J. and Bodnar ,CJ. (1999). Substance abuse during pregnancy: An estimate of the number of pregnant substance-abusing women in the Lower Mainland who require medical stabilization of pregnancy. Unpublished paper prepared for BC Women's Hospital and BC Centre of Excellence for Women's Health.

¹⁷ Ibid. (1998).

¹⁸ For the sake of this report, any physician who provides primary care services will be termed a family physician. This term includes both family physicians and general practitioners.

¹⁹ BC Vital Statistics.(2004) *Birth Related Statistics*.

of births were managed by FPs and 28 per cent were managed by OBs, representing a 21 per cent decrease in FP-managed deliveries. As of 2003, there were 1,032 FPs in BC delivering babies which represents one-third of FPs.²⁰

It is becoming increasingly difficult to attract new physicians to maternity care due to the demanding lifestyle, practitioner's fear of litigation, and lack of adequate remuneration.^{21 22} In rural and remote areas with hospitals with a small number of annual births, FPs may find their intrapartum skills are rarely used, leading to a loss of confidence.²³ As well, these physicians report working under strained conditions due to a lack of specialist back up to handle emergency situations and hampered transportation services due to unpredictable weather conditions.

The advancing age of BC's FPs is also a growing concern. In 2003, the average age of practicing physicians was 47.1 years. According to a British Columbia Medical Association (BCMA) survey, in the next five years, between 25 to 43 per cent of BC's physicians will retire.²⁴ While UBC has expanded its medical school seats, fewer new FP graduates are choosing to enter obstetrics and may not be able to make up for the loss of FP obstetrics providers through retirement.

While BC is experiencing a crisis in the number of physicians providing maternity care, the picture is not as bleak as it appears. Compared to other provinces, BC still has one of the highest rates of FPs delivering babies in the country. In Ontario the crisis is even greater with only 12 per cent delivering babies, while in Quebec that number drops to 7.4 per cent.²⁵

²⁰ Provincial Health Services Authority Statistics (2004); Knowledge Management and Technology Division.

²¹ Klein MC. (2000). Presentation: Family Practice maternity care. The future of maternity care in Canada: crisis or opportunity? National Conference. Nov 24-25, 2000; London, Ontario.

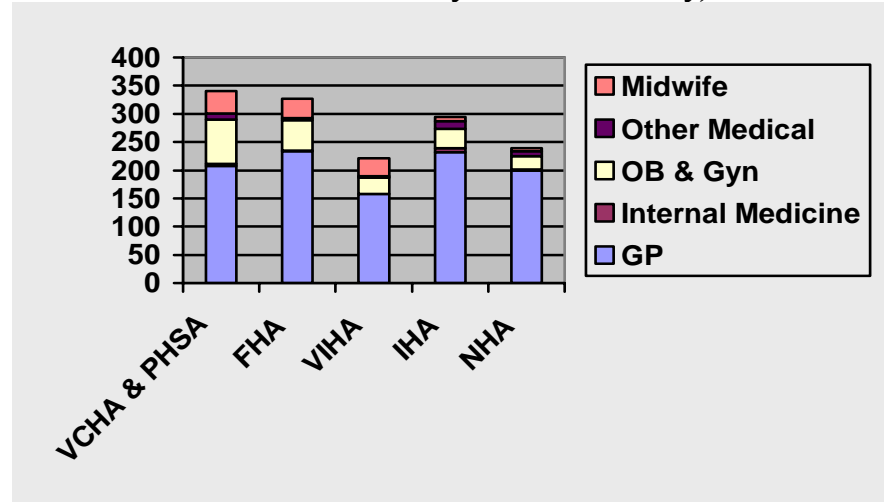
²² National Family Physician Survey.(2002) The Janus Report. College of Family Physicians of Canada. 1997/1998. Canadian Family Physician.. 46:493-548.

²³ Rogers J.(2003) Sustainability and collaboration in maternity care in Canada: dreams and obstacles. CJRM:8(3):193-8.

²⁴ BCMA. (2004). Specialty Care in BC: A System in Distress. A discussion paper by BC's Physicians, June 2004. Vancouver, BC: BCMA.

²⁵ Reid AJ, Fraba-Gubins I, Carol JC. (2001) Results of the 2001 National Family Physician Workforce Survey (Weighted Data), The Janus Report. Mississauga (ON): College of Family Physicians of Canada.

Exhibit 2: Obstetrical Providers by Health Authority, 2003



Registered Midwives

Midwives are relatively new providers in BC’s maternity care delivery system. Publicly-funded since 1998, there are currently only 108 registered midwives in the province. Their low numbers, along with an annual cap of 40 births per annum limits midwives’ ability to deliver a large number of babies.²⁶ Hence, midwives’ currently provide care to less than five per cent of pregnant women.

While the demand from women for midwifery care is high, especially in urban areas, the limited number of spaces in midwifery education programs mean there are not enough new graduates to make up for the loss of FPs providing obstetrical services.²⁷ A lack of funding for Prior Learning Assessment specific to midwifery also acts as a barrier to the integration of foreign-trained midwives and further limits the ability of midwifery to bolster the numbers of primary maternity care providers in BC.²⁸

²⁶ The 40 courses of care or births per annum cap is a funding cap agreed to between the Midwives Association of BC and MOHS.

College of Midwives of British Columbia. <http://www.cmbc.bc.ca/doccs/list.htm>

²⁷ In BC there are only 10 seats available per year in the four-year program at the University of British Columbia.

Tyson H. (2003). Developing a plan for growth and sustainability in midwifery practice. In: Kornelsen J, editor. *Midwifery: Building our Contribution to Maternity Care*. Proceedings from the Working Symposium; 2002 May 1-3; Vancouver, Canada. Vancouver: BC Centre of Excellence for Women’s Health.

²⁸ Kornelsen J. (2003) *Solving the maternity care crisis: Making way for midwifery’s contribution*. Vancouver; BC Centre of Excellence for Women’s Health: Policy Series.

Obstetricians

Obstetricians are highly-trained specialists with expertise in complex pregnancies and childbirth. Women with high risk pregnancies generally have an OB as their main care provider, while other women may receive specialist advice or emergency support from an obstetrician while being primarily managed by an FP or midwife.

However, in urban areas, the declining number of FPs providing obstetrical care is resulting in an increasing number of referrals to OBs for the provision of low-risk pregnancy care.²⁹ In 2003/04, OBs attended 41 per cent of deliveries, however the data do not indicate if these providers were the primary caregivers throughout the pregnancy. Furthermore OBs, who have taken up most of the delivery shortfall in BC are, like FPs, in extremely short supply. In 2003, there were 221 OBs attending deliveries in BC.³⁰ In Canada as a whole, the ratio of obstetrician/gynecologists per 100,000 persons fell from 5.66 to 5 between 1986 and 2000 while the functional number has dropped even more as a result of the withdrawal of many OBs to gynecologic work. Facing similar pressures as FPs, OBs are withdrawing from obstetrical work. This situation is not likely to improve as 30 per cent of Canada's OBs are 55 years of age or older and likely retire within the next decade.

GP Specialists

FPs with specialist skills such as anaesthesia or with caesarean section capability are a vital resource to their communities. Their skills are in high demand in many rural and small communities where obstetricians or anaesthetists are not available. Anaesthesiologists are skilled in providing epidural, spinal and general anaesthesia to pregnant women and caring for them in emergency situations. FPs with caesarean section skills provide emergency back up in the case of a complication or emergency during pregnancy and childbirth.

However, the numbers of FPs performing caesarean sections and providing anaesthesia are declining. In 1991/92, there were 85 FPs performing caesarean sections, but by 1999/00, there were only 52 FPs providing this service in BC.³¹ This means access to caesarean sections for women in small and rural communities is declining,

²⁹ Kornelsen J. (2003) Solving the maternity care crisis: Making way for midwifery's contribution. Vancouver; BC Centre of Excellence for Women's Health: Policy Series.

³⁰ Provincial Health Services Authority Statistics (2004); Knowledge Management and Technology Division.

³¹ Medical Services Plan, 1991/92 to 1993/94 and MSP Claims File, 1994/95 to 1999/00.

forcing them to travel out of their home community for the birth of their baby.

Registered Nurses

Nurses are the backbone of maternity care service delivery in BC. They have a variety of roles and responsibilities when it comes to the care of women and their families during pregnancy, childbirth and the postpartum period. Nurses working in acute care maternity units provide labouring women with clinical and emotional support. Community Health Nurses work in the community setting and have a significant role in providing postpartum support to women and their families during the newborn period.

The state of BC's nursing supply is in crisis. In 2002, BC had 67.2 RNs per 10,000 population, which tied with Ontario for the lowest ratio in Canada.³² In 2003, there were 29,982 RNs in the province, but the average age was 45.2 years³³ and 27.5 percent of RNs were over 55 years. The retirement of RNs in the next few years could have a huge impact on the province's supply of nursing providers. BC is projected to lose 32 per cent (8,718) of its RNs by 2006 if those currently employed retire early at 55 years of age. However, if they continue to work past age 55, BC will only lose 14 per cent of its nursing workforce.³⁴

The shortage of nurses is having a direct effect on hospitals ability to recruit nurses with perinatal experience.³⁵ Another factor affecting nursing support for maternity care is that the basic nursing education offered by the majority of BC's nursing programs does not include sufficient maternity training to meet entry level expectations for nurses to staff labour and delivery units – for several reasons. The most prevalent reason for this problem is the inability of nursing students to get maternity placements. The lack of experienced maternity care nurses due to aging and burn-out makes mentoring difficult. The result is that hospitals staff their maternity units with inexperienced nurses or new graduates. In 2002, there were only 1,684 or six percent of RNs specializing in maternal and newborn care in BC.³⁶

³² CIHI. (2003b). *Workforce Trends of Registered Nurses in Canada, 2002*. Ottawa, ON: CIHI

³³ RNABC. (2003b). *RNABC Annual Report 2003*. Vancouver, BC: RNABC.

³⁴ CIHI. (2003a). *Bringing the Future into Focus: Projecting RN Retirement in Canada*. Ottawa, ON: CIHI

³⁵ VIHA News Release. (2004). *Maternity Service for Mount Waddington to be Consolidated*. July 19, 2004.

³⁶ CIHI. (2003a). *Bringing the Future into Focus: Projecting RN Retirement in Canada*. Ottawa, ON: CIHI

Pediatricians and Neonatologists

Pediatricians and neonatologists are responsible for looking after the medical needs of babies, including premature infants, those with congenital abnormalities or those who are ill. Pediatricians provide hospital and community services for all children while neonatologists specialize in the care of newborn babies, supervising special care and high dependency services.

There are approximately 322 pediatricians and neonatologists in BC and like other physicians, the majority will reach retirement in the next decade. Their average age of Canadian pediatricians was 48 years in 2001, with none under the age of 30 and 18 per cent over the age of 60.³⁷

Doulas

Doulas are trained lay women who provide one-to-one continuous emotional and physical support to women in the intrapartum stage of their pregnancy. In BC, doulas are not licensed by a registered body or publicly funded. Women interested in obtaining doula support during childbirth must privately hire and negotiate a fee for service with a respective doula. Doulas of North America reports that it has 125 BC members, 83 who are certified by the organization.³⁸

Other Providers

Women may also require care from other health care service providers, including maternal fetal medicine specialists, sonographers, paramedics, mental health specialists, pharmacists, physiotherapists, dieticians, social workers, lactation consultants and others.

3e. Critical Junction

What the provider demographic picture reveals is that BC is at a critical junction in terms of the provision of maternity care services. If adequate support and sustainable models of maternity care are not implemented in the near future, BC could follow the path of Ontario and Quebec where the majority of deliveries are attended by an obstetrician. Given the rising attrition rate of obstetricians providing maternity care, this default position may not be feasible in BC, nor is it an appropriate use of obstetricians high-level skills and training.

³⁷ CIHI 2004. Giving birth in Canada -- providers of maternity and infant care.

³⁸ Doulas of North America. www.dona.org

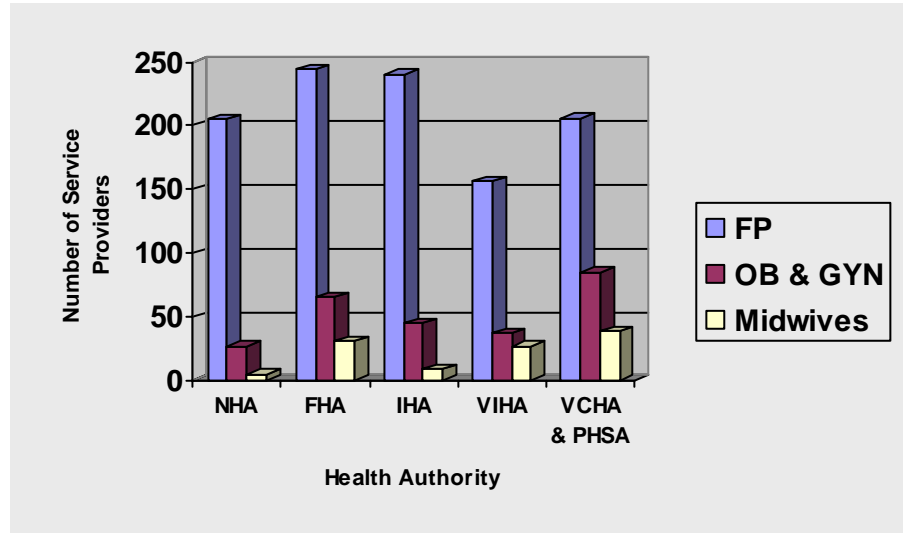
BC has an opportunity to establish new models of service delivery that support primary maternity care providers such as FPs and midwives to better meet the needs of women and their families. Feedback from stakeholders supports research findings demonstrating that service requirements must drive the workforce requirements for maternity care in this province. This report recognizes the tensions between the numbers of available providers, the current models of maternity care delivery, the current maternity care provider training programs and the delivery of a safe and accessible service. However, planning for the future maternity care workforce must take into account the models of service delivery, recognizing that no one profession alone can solve the problem. There are too few family physicians providing intrapartum care, too few obstetricians available, too few nurses with maternity care experience, and too few midwives for any one group to be able to make a significant difference.³⁹

3f. Provider Projections

Detailed work is required to set out the workforce implications concurrent with the guiding principles and recommendations laid out in this report. It was not possible within the project's timeline to provide an accurate projection of workforce needs that are in line with the recommendations to develop collaborative, locally-based, women-centered service models. Instead, we offer a conservative estimate of future workforce numbers based on current delivery patterns, assuming that the provision and models of obstetrical care by all providers (family physicians, obstetricians and registered midwives) remains constant.

³⁹ Rogers J.(2003) Sustainability and collaboration in maternity care in Canada: dreams and obstacles. CJRM:8(3):193-8.

Exhibit 3: Projection of Principal Maternity Care Providers Required within Current Delivery Models by 2010 by Health Authority



An analysis of the data tell us that given current patterns of maternity care delivery, BC will need 1,053 family physicians to provide obstetrical care by 2010 to match the expected increase in births, an increase of 21 providers from 2003. As the proportion of increases in births is highest in the Interior Health Authority, this HA will require the largest increase in FP maternity care providers with 5 additional providers needed to keep up with demand.

If obstetricians continue to provide the same level of maternity care to women, BC can expect to require 37 additional obstetricians by 2010. If the current model of midwifery care remains in place with midwives capped at 40 births per annum, the projections show their providers numbers as remaining constant, with no increases noted.

Caution must be noted in interpreting these data as they do not take into account changes in the models of care delivery that will have a direct impact on the configuration of providers. Stakeholders suggested we need to train our maternity care providers differently so that we are not basing our maternity system on the needs of service providers, but on the needs of women. The next phase of work to be undertaken would be to develop a comprehensive service estimate based on collaborative models of maternity care.

3g. Other Challenges in the BC Picture

Regionalization

Alongside the issue of a decreasing supply of maternity care providers is the fact that the centralization of health care services due to regionalization and system restructuring is having a noticeable impact on women's access to maternity care services. This general trend towards centralization and consolidation of services is especially evident in rural areas where the ability to deliver in one's own community, even with access to a local hospital, is being reduced for rural women.^{40 41 42 43} In British Columbia since 2000, 13 small maternity services have closed their doors and three others have suspended services temporarily.⁴⁴ Meanwhile, in other small communities, a limited number of family physicians provide all of the maternity care, sometimes backed by a GP or surgeon who can manage cesarean sections. Physicians in these communities struggle with considerable responsibility, compromised lifestyle and inappropriate remuneration.⁴⁵

This current trend in reduced access to locally-based maternity care services is causing labour and birth to become a crisis event for rural women, fraught with anxiety due to the uncertainty regarding the planning and location of the birth. Socially disadvantaged women are most affected by this trend, leading to an array of social and health consequences, including the development of strategies by women to mitigate current hospital maternity policies such as: presenting at local hospitals in advanced stages of labour; having unassisted home births; and adjusting conception to correspond to birthing during seasons where weather may be less of an obstacle to travel. These strategies may further damage the fragile fabric of rural community health services and lead to unintended effects on the community itself.⁴⁶

⁴⁰ Hutton-Czapski P.(2001) The state of rural healthcare. Presentation to the Standing Senate Committee on Social Affairs, Science and Technology. May 31.

⁴¹ Rourke JTB. (1998) Trends in Small Hospital Obstetrical Services in Ontario. *Can Fam Physician*; Oct;44: 2117-2124.

⁴² Hutton-Czapski P.(1999) Decline of obstetrical services in northern Ontario. *Can J Rural Med*;4 (2):72-6.

⁴³ British Columbia Reproductive Care Program. (2000) 1999 Report: Biannual Hospital Perinatal Surveys and Nursing Skills & Competency Survey. British Columbia Reproductive Care Program.

⁴⁴ BCRCF report, 2004.

⁴⁵ Responses from "Questionnaire for Short Term Maternity Care Enhancement". (2004) General Practice Services Committee, British Columbia, September 2004.

⁴⁶ Klein MC., Christilaw J, Johnston SMB.(2002) Loss of maternity care: the cascade of unforeseen dangers. *CJRM*;7 (2):120-1.

Challenges in New Provider Acceptance

Another issue that has impacted on maternity care provider relationships and women's access to care in the past is the often strained relationship between physicians, nurses and midwives. It has been well documented that the introduction of midwifery as a regulated practice in BC in 1998 was fraught with challenges, such as misunderstanding and resentment from other maternity care providers.

While relationships are now more positive at an interprofessional level, there is still evidence of strain. Barriers exist among professionals with different educational backgrounds and maternity care is still practiced in a somewhat hierarchical system. Physicians historically maintain the most power and status and have generally not welcomed new practitioners to the system.⁴⁷ In order to move beyond this, there must be a concerted effort by all providers to work with each other in a mutually-respectful and collaborative manner.

⁴⁷ Klein MC., Christilaw J, Johnston SMB.(2002) Loss of maternity care: the cascade of unforeseen dangers. CJRM;7 (2):120-1.

***Good maternity services
place the mother and her
baby at the centre of care,
and plan and provide
services to meet their needs.***



Guiding Principles: A Philosophical Framework for Maternity Care Services

A consistent picture emerged through the MCEP consultation process that a women-centered approach to developing maternity care services would support a range of options for women and their families and for providers based on local resources and capacity.

4a. Women-centered Care

A women-centered approach to maternity care is one in which services are located in the context of primary care with the recognition that “for the majority of women pregnancy and childbirth are normal life events.” In this approach, “good maternity services place the mother and her baby at the centre of care, and plan and provide services to meet their needs.”^{48 49 50} Developing women-centered care relies, in part, on understanding women’s preferences and needs with respect to care. It also involves engaging women and their families in the processes of planning and delivering services.

Appendix 19 provides an overview of the literature on women’s expectations for their maternity care. There is a growing body of literature confirming that childbirth is an important life event for women, the importance of which extends beyond the immediate experience of giving birth and the initial transition to becoming a mother.⁵¹ Studies have documented the impact of childbirth on women’s identities and the value that women place on the experience.⁵² In Scotland, focus groups and interviews conducted

⁴⁸ Maternity Standard: National Service Framework for Children, Young People and Maternity Services(2004) Department of Health and Department for Education and Skills. National Health Service, United Kingdom:London. October.

⁴⁹ Simkin P. (1991) Just Another Day in a Woman’s Life? Women’s Long-Term Perceptions of their First Birth Experience. Part I, BIRTH, 18(4):203-210.

⁵⁰ Simkin P. (1991) Just Another Day in a Woman’s Life? Part II: Nature and Consistency of Women’s Long-Term Memories of their First Birth Experience. BIRTH, 19(2):64-81.

⁵¹ Nichols F and Gennaro S. (2000) The Childbirth Experience in Childbirth Education: Practice, Research and Theory. 2nd Ed., Nichols F. and S. Smith-Humenick (Eds). Philadelphia:W.B. Saunders Co.

⁵² Zadoroznyi, M. (1999) Social Class, Social Selves and Social Control in Childbirth, *Sociology of Health and Illness*: 21(3):267-289. (p.279)

with approximately 100 women suggested that women experienced their contacts with health care providers as fragmented and impersonal; that the various health care providers with whom women interacted throughout their course of care had very different approaches, styles and ways of working; that women's good experiences of care were predicated upon good relationships with health care providers who communicated well among themselves and listened to what the woman wanted or felt; and that integrated care and good quality relationships were achieved through continuity of care.⁵³ Overall, what was most important was that "everyone involved in care-giving knew what other health professionals had done or said, had a shared approach to that woman's care, and knew about the woman and what she herself wanted."⁵⁴

Partners, fathers, family and peers also provide significant influence and support for women throughout pregnancy and motherhood. Maternity services can support this relationship by encouraging fathers and family members to become involved in supporting the woman and in the care and upbringing of children.⁵⁵

Stakeholders during the consultation process agreed that women's needs must take first priority in the development of any new models of care. Services need to be designed to support a woman and her baby's journey through pregnancy and motherhood, offering support and encouragement to have as normal a pregnancy and birth as possible.

4b. Guiding Principles

Using the women-centered foundation as the base, stakeholders wanted to develop a set of guiding principles which would inform the development of BC-based models of care as well as their implementation at the community level. They wanted the principles to set out a broad philosophical approach and represent the shared values that stakeholders agreed are critical to the delivery of maternity care services. There was general consensus for the principles to be underpinned by the belief that for the majority of women, pregnancy and childbirth are normal life events requiring minimal medical intervention.

⁵³ While the central maternity health care provider in Scotland is a midwife and hence the model does not directly apply to British Columbia, there are nevertheless important lessons to be learned about what women want that are likely relevant in this province.

⁵⁴ A Framework for Maternity Services in Scotland. Ministry of Health and Community Care, Scotland. February 2001.

⁵⁵ Maternity Standard: National Service Framework for Children, Young People and Maternity Services. Department of Health and Department for Education and Skills. National Health Service, United Kingdom:London. Oct 2004.

Guiding Principles

A B.C. Model of Maternity Care should meet the needs of women and their families by providing:

- 1. Equity of Access:** Provide a flexible, diversity-sensitive, high quality and accessible service.
- 2. Primary Care:** Provide all women with uncomplicated pregnancies midwife - and/or family physician-led models of care.
- 3. Choice of Location and Method:** Give women the right to choose how and where they give birth, depending on available human and financial resources. This choice should be supported by adequate transportation services, high quality information and evidence-based clinical advice that allows women to take part in the decision-making process.
- 4. Women's Empowerment:** Support and encourage the increased participation of women in decision making by providing women with information about choices in all aspects of childbirth and fetal health.
- 5. Seamlessness:** Provide a fully integrated, provincial childbirth service accessible to women and their newborns in a timely manner with strong working relationships between primary, secondary and tertiary obstetric, anaesthesia, nursing and neonatal care services.
- 6. Timeliness:** Provide effective arrangements for managing the prompt transfer and treatment of women and their babies experiencing problems and complications.
- 7. Women's Participation:** Involve women in the planning, review and delivery of local hospital and community maternity services.
- 8. Continuity of Care:** Encourage providers who practice obstetric care to develop structured on-call systems, and offer women the opportunity to acquaint themselves with all caregivers in the system well before delivery where possible.
- 9. Valuing Providers:** Provide appropriate incentives, support, education and training for all maternity care providers, acknowledging the level of responsibility they carry and the skills they need.
- 10. Team Work:** Foster an interdisciplinary model of care with an understanding of all professional roles to maximize the quality and comprehensiveness of care.

4 b i. Establishing a Philosophical Approach to Maternity Care

The guiding principles were initially devised by piecing together and revising guidelines from a variety of sources, including the Society of Obstetricians and Gynecologists of Canada, Health Canada's Family Centered and Newborn Care Guidelines, the Canadian Medical Association, Scotland's Framework for Maternity Care Services and the UK's Antenatal Care Guidelines. All of these sources support the development of women-centered maternity care services to ensure the long-term sustainability of maternity care delivery systems.^{56 57 58 59 60}

The principles were reviewed and reworked by the Working Group over the three consultation sessions. Input into the guidelines was also provided by members of the Provincial Women's Health Network and other stakeholders who were invited to provide feedback on the wording and intent of the principles.

The guiding principles are intended to help inform and direct local maternity service strategies. They also provide a framework to assess the implementation of local strategies and to evaluate their progress, recognizing that it is up to individual communities to determine how they can best provide women-centered sustainable maternity care services. This requires input from women and their families, the caregivers and the local health authority. This concept of sustainability includes providers being available, able and willing to provide maternity care, women having access to the appropriate provider, and resources being available to adequately finance the maternity care system.

⁵⁶ A Framework for Maternity Services in Scotland. Ministry of Health and Community Care, Scotland. February 2001.

⁵⁷ Maternity Standard: National Service Framework for Children, Young People and Maternity Services. Department of Health and Department for Education and Skills. National Health Service, United Kingdom:London. Oct 2004.

⁵⁸ Maternity Coalition, Australian Society of Independent Midwives Community Midwifery WA Inc. National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia. Sept.2002.

⁵⁹ Midwifery: Building our contribution to maternity care. Proceedings from the Working Symposium May 1-2, 2002 Vancouver, BC. Edited by Jude Kornelsen. Vancouver, BC: BCCEWH.

⁶⁰ Public Health Agency of Canada. (2002). Chapter 1: Introduction and Philosophy. Family-Centred Maternity and Newborn Care. Ottawa, ON: Public Health Agency of Canada, Division of Childhood and Adolescence.

4 b ii. Developing a Maternity Care Pathway

In order to create a women-centered maternity care system for BC that promotes the philosophy behind the guiding principles, government, providers and women need to take the next step and develop a standardized maternity care pathway outlining a woman's progress through the maternity care system and the services she can expect to receive at each stage of her maternity care.

The pathway would set up the minimum expectations of what a woman will receive from her obstetrical care. Developed by key stakeholders, a BC-based maternity care pathway would formalize evidence-based protocols and guidelines into direct, women-centered care. A care pathway describes the routine progression of a woman through the antenatal period as well as illustrating conditions or situations to demonstrate how the standards will be implemented in particular circumstances.⁶¹ The purpose of the pathway is to ensure the same high standard of care is provided to all women, regardless of location or service provider.

From this pathway will flow logical suggestions for how maternity care providers should be reimbursed for their work in supporting women's obstetrical care. The guidelines will also assist in determining what services can be provided in a team context by allied providers such as community health nurses and help reduce the duplication in services that currently occurs between providers.

Recommendation #1

The Ministry of Health Services support the development of a women-centered maternity care pathway for British Columbia.

⁶¹ Maternity Standard: National Service Framework for Children, Young People and Maternity Services. Department of Health and Department for Education and Skills. National Health Service, United Kingdom:London. Oct 2004.

Collaborative care is a multidisciplinary and multi-agency approach to the delivery of maternity care, where providers work together in a coordinated manner to ensure the equitable provision of high quality, clinically effective care.



Sustainable Models of Care: Supporting Collaborative Care Solutions

The guiding principles support the development of a model of care that links together maternity care providers and organizations offering primary, secondary and tertiary maternity care services to work in a coordinated and collaborative manner to ensure the equitable provision of high quality, accessible, clinically effective care. The principles speak to the creation of a multidisciplinary and multi-agency approach to the delivery of maternity care that places women and their babies at the centre of care.

The principles reflect the vision of MCEP stakeholders that in order to support the long-term sustainability of maternity care in BC, we need to foster supportive working relationships between providers and between organizations. While the mandate of the 2004 Working Agreement between BCMA and MOHS was to focus on the sustainability and reimbursement of physicians providing obstetrical care, the consultation process revealed that in fact, sustainability depends on collaboration between all parties. Participants stated that collaborative models of care are the best way to implement and uphold the philosophical approach to maternity care outlined in the guiding principles.

The following section outlines the issues behind the need to establish models of maternity care reflecting integrated, collaborative working relationships and offers a recommendation to support their development. This report does not recommend a single prescriptive model for the province but rather offers a range of options under a women-centered, locally-based framework of care delivery that individual health authorities and communities can use to develop collaborative solutions that are unique and appropriate to their needs.

5a. What is Collaborative Care?

A general definition of collaborative care describes it as a jointly comprehensive approach to meeting patients' health care needs.⁶² Interdisciplinary collaboration is defined as an approach to care, distinguished by elements such as first contact, continuous, comprehensive and coordinated care for a specific population.⁶³ Interdisciplinary collaboration is described as having the following attributes:⁶⁴

- Development of a common purpose or care outcome;
- Acceptance and recognition of complementary skills and expertise among different providers;
- Effective coordination and communication among providers;
- Collaboration as a framework for strengthening inter-professional communication and increasing the efficient use of health care resources.

While collaborative care teams may consist of providers from the same discipline working together in a group practice setting, they are generally interdisciplinary in nature. Collaborative maternity care practices join professionals from various health disciplines together to establish new group practices bound by a common philosophy and commitment to the provision of high quality care for women and their babies.⁶⁵

Evidence supports the fact that team-based models of primary health care lead to increased job satisfaction among health care providers, improved patient service, improved population health, and a more efficient use of health care resources.⁶⁶ There is also evidence to support the fact that collaborative models of maternity care improve

⁶² National Joint Practice Commission (1981) Guidelines for establishing joint or collaborative practice in hospitals. Chicago: The National Joint Practice Commission.

⁶³ Interdisciplinary Primary Care Models. (1997) Prepared by The Working Group on Interdisciplinary Primary Care Models for the Advisory Group of Interprofessional Practitioners.

⁶⁴ Stonebridge C.(2004) Primary Health Care: Principles and Framework Literature Review. Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative. www.eicp.ca

⁶⁵ Lyons,N;Reinke,C;Sutherland,K & Zelenkov,K.(1992) The Ultimate Birth Center: A Collaborative Model for Innovation. Nursing Clinics of North America. March. 27(1):99-107.

⁶⁶ Hasselback P et al. (2003) The Taber Integrated Primary Care Project – Turning Vision into Reality. www.chsrf.ca/final_research/ogc/hasselback_e.php?mode

health outcomes for women and their babies, are cost-effective and increase women's satisfaction.⁶⁷

5b. Essential Components

There are key elements of an integrated, collaborative model of maternity care that are essential to its successful implementation at a local level and for its acceptance by both women and providers.

Research points to a number of essential components:^{68 69 70}

- Desire to maintain local maternity services on the part of the community and caregivers;
- Mutual respect by the members of the maternity care team and a valuing of the skills and contributions of each member, acknowledging their interdependence;
- Communication that encourages dialogue designed to explore different perspectives, and a willingness to discuss differences;
- Non-hierarchical structure in which all participants work together with equal power and responsibility;
- Professional competence and awareness of the strengths and limitations of one's own and others' disciplines;
- Shared responsibility and accountability;
- Shared values, goals and vision;
- Shared clinical protocols;
- Consistent data collection and review to evaluate practices in order to optimize maternal and neonatal outcomes;
- Willingness to commit time and energy to the process;
- Commitment of leaders to reinforce collaborative behaviour.

⁶⁷ Keleher K.(1998) Collaborative Practice: Characteristics, Barriers, Benefits and Implications for Midwifery. *J Nurse-Midwifery*. January/February. 43(1):8-11.

⁶⁸ Rogers J.(2003) Sustainability and collaboration in maternity care in Canada: dreams and obstacles. *CJRM*:8(3):193-8.

⁶⁹ Davies C (2000) Getting health professionals to work together: there's more to collaboration than simply working side by side. *BMJ*; 320:1021-2.

⁷⁰ Stapleton SR. (1998) Team-building: making collaborative practice work. *J Nurse Midwifery*;43(1):12-18.

5c. What Do Collaborative Care Models Look Like?

Depending on local resources and capacity, a collaborative model of primary maternity care could take a variety of forms. Collaboration between providers could be simply establishing a shared call network among physicians working in the same or neighbouring communities who provide obstetrical care.

In rural settings in which there are a limited number of providers, primary health care teams could be established to provide some level of maternity care alongside the provision of other primary care services, such as chronic disease management and mental health services. Several health authorities have already established team-based models for the delivery of primary care services as part of their Primary Health Care renewal strategies. Maternity care could be incorporated into these primary care models. For example, the Fraser Health Authority has developed shared care models for mental health services, renal care, palliative care and chronic disease management in which primary care providers work with specialized multidisciplinary teams in a community health centre and primary health care organization setting.⁷¹ These models could be used to develop similar shared care teams to deliver locally-based primary maternity care.

Another option is to establish a shared care family practice obstetrics model in which a heterogeneous group of committed family physicians and/or registered midwives and/or obstetricians, along with allied providers such as nurses and/or doulas, share the delivery of primary maternity care through a combined system of shared call, office practice and maternity clinics. For example, Penticton Regional Hospital recently established the South Okanagan Family Practice Maternity Service in which a group of five local family physicians provide prenatal, intrapartum and postpartum care to women and their families through the sharing of clinics and call.⁷² The health authority provides clinic and office space for the service and covers the cost of administrative support services.

Another example of a team approach is the South Community Birth Program. In this pilot program, a team of family physicians, midwives, community health nurses and doulas work collaboratively to support comprehensive care for expectant and new mothers in

⁷¹ Fraser Health Authority.(2004) Primary Health Care Initiatives FAQ. www.fraserhealth.ca/Initiatives/PrimaryHealthCare/Plans+.htm

⁷² Creating a Sustainable Future for Maternity Care in the South Okanagan: A Proposal for Primary Maternity Care Services at Penticton Regional Hospital. Interior Health Authority, May 2004.

South Vancouver. In this program, FP's and midwives share both call and clinic work.⁷³

These are just a few examples health authorities, providers and women could use to establish a collaborative maternity care model that is unique and appropriate to the needs of individual communities.

5d. Collaboration Challenges

Collaboration requires flexibility, progressive approaches and effort. Providers from a variety of disciplines may be unprepared to work in a shared care environment due to lack of training, information or experience. In addition, professional allegiances, responsibilities and issues of territoriality may impede collaboration.

For example, the introduction of midwifery as a regulated practice in BC in 1998 was fraught with misunderstanding and resentment from other maternity care providers.⁷⁴ While relationships are now more positive at an inter-professional level, there is still evidence of strain. In order to move beyond this, there must be a concerted effort by all providers and leadership from their professional associations to promote collaborative care initiatives.

Scope of practice is also an issue, especially in collaborative models in which family physicians and midwives share care. Midwives current scope of practice is much more limited than a family physician's due to the 40 births per annum cap agreed to when midwifery was initially legislated in BC between the Midwives Association of BC and MOHS, impeding their ability to share care on an equitable basis with physicians.

Funding systems are perhaps the biggest barriers to shared care models. Different funding schemes - fee for service and course of care payment models of compensation for physicians and midwives respectively -impede collaboration. New funding models are needed that move away from the traditional negotiated agreements between professional associations and the provincial government. The next chapter provides an examination of funding challenges and suggests solutions to cultivate and support shared care models.

⁷³ Call and birth attendance is shared equitably among FP's and midwives in this program as the College of Midwives of BC has lifted the 40 birth per annum cap for midwives involved in this pilot project.

Harris, SJ and Saxell, L. (2003-4) Collaborative Maternity Care: The South Community Birth Program. *Cdn J Midwifery Research & Practice*. Vol. 2, No.3.

⁷⁴ Kornelsen, J.(2000). *Pushing for Change: Challenges of Integrating Midwifery into the Health Care System*. British Columbia Centre of Excellence for Women's Health.

Recommendation #2

The Ministry of Health Services promote and support women-centered, collaborative, team-based service models among all maternity care providers.

***The delivery of high quality
maternity care services is
dependent on all providers
being trained and supported
to work within the full range
of their competencies.***



Resource Allocation to Support Collaborative Care

This chapter offers specific recommendations regarding the allocation of resources to support collaborative models of maternity care at a provincial and regional and local level. Implementing local collaborative models of maternity care requires consideration of various financial opportunities and capacities, both with respect to the direct compensation of physicians and other maternity care providers and also with respect to support of other elements of the system such as infrastructure and education.

The consultation process confirmed the importance of appropriately valuing the contributions of health care providers through fiscal means but stakeholders stressed that support in other forms was also valuable. Health authorities, professional associations and government each have a role to play in resource allocation to support collaborative maternity care in BC.

The recommendations are divided into four sections. The first section points to the need to support reimbursement options for family physicians delivering babies that encourage their continued participation in obstetrics as well as promote collaborative care. The second section examines mechanisms to support the integration of other maternity care providers, including midwives and nurses, into this model of care. The third section describes the role health authorities can play in supporting the development of collaborative models of maternity care at the regional and community level. The last section highlights the need to support educational initiatives that both promote and support the development and sustainability of collaboration among maternity care providers.

6a. Valuing Physicians

Stakeholders stressed that in order to reverse the trend of family physicians leaving the practice of obstetrics and encourage long-term sustainability, it is important to value the work they do through appropriate reimbursement mechanisms. These mechanisms include

funding to support current best practices that focus on the type of maternity care women and their babies need. The current reimbursement system unfortunately does not always do that.

6 a i. Current Incentives to Promote Family Practice Obstetrics

An in-depth examination of the issues and challenges currently facing the physician reimbursement system can be reviewed in Appendix 11. Currently, most family physicians and obstetricians are paid on a fee for service basis through MSP as negotiated between the BCMA and the Government. Billing fee for service can be an open-ended process. This is commonly cited as a disadvantage as it can lead to the overuse of health care services. However, there are limits on physicians' ability to bill for certain types of fees, such as the number of prenatal visits. These are set to prevent overbilling as well as to change physician practice patterns.

As the current fee for service payment model does not encourage family physicians to deliver babies, a number of initiatives have been implemented recently to provide incentives to support family practice obstetrics, through both traditional and collaborative models of care.

One initiative is the GP Obstetrical Incentive fee that provides a bonus of 50% for the first 25 deliveries attended by a family physician annually. According to stakeholders, this incentive, meant to support low volume obstetrical providers, has been perceived positively by physicians as it compensates providers to maintain their obstetrical skill set and its benefits are widely distributed among providers. However, stakeholders noted one barrier in the incentive that limits its effectiveness – physicians can only bill for the incentive for a maximum of one birth per day. Physicians have said that the timing of deliveries is not within their control.

A second initiative, implemented in the fall of 2004, is in line with the recommendations and guiding principles outlined in this report. The Maternity Care Network Initiative provides a Service Enhancement Fee for family practitioners who form and/or work in shared care networks, which have been shown to provide a more sustainable basis on which to practice primary care obstetrics.

This initiative takes the form of a quarterly supplement of \$1250 for family physicians who work in groups of four or more to share call, as well as clinics and office practice where feasible. It was intended to be a one-time initiative to support physicians while this project examined the issues and made reimbursement recommendations to

support the long-term sustainability of physicians practicing obstetrics. It will be offered for two quarters, ending March 31, 2005.⁷⁵

Feedback from stakeholders suggests that this initiative has encouraged some solo practitioners to form groups and that it offers a sustainable work environment for practitioners who have found solo practice challenging or who have been taking frequent call. The one element of this initiative that has proven controversial is the minimum group size of four providers. However, research suggests that many physicians do not consider it reasonable to be on call more than one night in five for the emergency department,⁷⁶ suggesting that a group of fewer than four providers does not provide adequate on-call coverage and off-call time when 24 hour/365 days a year care is required.⁷⁷ In order to support physicians in rural communities that may not have the local physician resources or capacity to form groups of four, a process has now been implemented to approve smaller groups under this funding arrangement.

There is a need for further education with regard to the disbursement of this fee to lessen the confusion about its requirements among providers. The goal of the Service Enhancement Fee is to offer a reimbursement model that will support collaborative models of care in the context of the unique blend of women, providers and geography within an individual community. Stakeholders supported the continuation of this initiative. The cost of this initiative, if the current model is extended, is estimated to be \$3.2 million per year.

In addition to the two initiatives reviewed above, two new fee codes were implemented in September 2004 to support collaborative care between family physicians and obstetricians. The new codes allow obstetricians to be reimbursed for supporting high risk cases. The first is for the management of complicated labour by an OB that allows them to bill \$516.65 (Item 04039) for a delivery while still allowing a family physician to bill \$516.65 (Item 14104) for the shared management of the same delivery. As well, Item 04038 allows OBs to bill \$171 for deliveries when they are called back for a second time to consult on a patient.

⁷⁵ Maternity Care Network Initiative , Ministry of Health, Updated November 4, 2004. <http://www.healthservices.gov.bc.ca/cdm/practitioners/maternitycare.html>

⁷⁶ Recruitment and Retention: (1997). Consensus of the conference participants, Banff 1996. *Can J Rural Med*;2(1):28-31.

⁷⁷ Rogers J.(2003) Sustainability and collaboration in maternity care in Canada: dreams and obstacles. *CJRM*:8(3):193-8

In addition, there are also programs in place to support continuing medical education, the provision of rural locums and rural incentives to improve physician supply problems.

6 a ii. Additional Reimbursement Methods to Promote Collaborative Maternity Care

There are a variety of other approaches BC could take to support and encourage family physicians to continue to practice primary maternity care. For example, stakeholders strongly supported the addition of two new items to the fee for service guide to recognize unpaid maternity care work. These items would:

- Allow physicians to bill three of the prenatal visits as counseling visits for prenatal care, one per trimester, if certain conditions apply. The conditions would include: a visit of at least 20 minutes in length, and discussion of a maternity counseling issue such as triple screen, ultrasound abnormalities, high risk conditions, and labour and delivery planning. Both FPs and OBs would bill these visits if relevant. The cost of this fee item is estimated to be \$3 million.
- Allow physicians to bill 50 per cent of a prenatal visit if a woman comes in for an unrelated medical condition which requires a prenatal checkup to determine fetal well-being and assist in management decisions. The estimated cost of this new fee is \$1.8 million.

Other suggestions identified during this consultation that fall under the fee for service rubric are to develop fee items to support complex deliveries and the unbundling of postpartum care. These suggestions will involve sections of General Practice and Obstetrics in the development of fee for service items. They will also require the BCMA tariff committee to strike a working group to develop ways to compensate family physicians for long and complex labours, day-time surcharges, and fees for “stand-by time”. In addition, this working group will need to examine ways to unbundle postpartum care from the delivery fee to allow appropriate compensation for unpaid work under the current billing system. Similar initiatives are underway in other jurisdictions. For example, in Ontario, fee item P038 pays rural doctors who attended a labour but had to transfer the patients care prior to delivery, and in Alberta, physicians may bill a fee for labour management and intent to deliver.

There is also the potential to establish fee for service savings targets based on the development of clinical maternity care guidelines.

Current best practice guidelines include recommendations about frequency of diagnostic testing, frequency of pre-natal visits for women experiencing their first or subsequent pregnancy, and other services related to obstetrical care. A committee could be tasked with reviewing and making recommendations regarding clinical guidelines for prenatal care and note where savings might be found that could be reallocated to partially fund other maternity care reimbursement initiatives.

There are other alternatives to the fee for service model of payment, such as a case-based system. In BC, registered midwives are currently paid on a per case basis, with a cap of 40 cases annually. The average billing per case for a midwifery patient is \$2582.

Another payment option for independent physicians is capitation. Currently, a small number of family physicians and obstetricians in BC are remunerated on a capitation basis in which they provide unlimited services to patients in a rostered service framework. However, BC's current capitation models do not adequately compensate the provision of maternity care and FPs in this model are now billing fee for service. Generally in capitation models, practitioners are paid an annual fee based on factors such as patient age and acuity. Both the capitation and case-based models work well in situations in which practitioners care for individuals with varying levels of health challenges, as they may require different levels of service⁷⁸. The risk of these payment systems is a perverse incentive to select patients on the basis of health status.

Some physicians are paid on a salary basis, similar to many other health care providers. In such a reimbursement system, providers are paid annually, although still independently, for their services. Studies demonstrate that many physicians find alternate payments plans more attractive methods of remuneration than fee for service as they encourage longer-term commitment to the practice of medicine⁷⁹. A Canadian Medical Association survey shows that even though 62 per cent of Canadian doctors derive their income from fee for service, only 37 per cent prefer that method of payment.⁸⁰

⁷⁸ Leavey, J & Yazganoglu, E.(2003) "Physician Compensation Project; Literature Review Highlights." Ministry of Health.

⁷⁹ A Blueprint for Addressing Physician recruitment and retention in rural and remote Ontario." (1998) A Joint project convened by the Ontario Regional Community of the Society of Rural Physicians of Canada and the Professional Association of Interns & Residents of Ontario. December.

⁸⁰ Martin, Shelley. (2000) CMA survey shows fee-for-service not dead yet. CMAJ, 163(5):7-25 as cited in Grignon, M, Paris, V & Polton, D. Influence of Physician Payment Methods on the Efficiency of the Health Care System, Commission on the Future of Health Care in Canada, November 2002.

Many countries use a mixed model approach to physician reimbursement. A mixed model approach blends more than one compensation scheme for physicians to minimize the disadvantages of any one system. For example, a disadvantage of the fee for service system is its tendency to increase volume of services, whereas a salary system may lead to fewer services provided. Many countries such as the United Kingdom use a mixed model approach.⁸¹ In BC some physicians receive sessional funding for part of their work and bill fee for service for other care delivery. A study of family physicians who attended deliveries in the Department of Family Practice at BC Women's Hospital & Health Centre found that more physicians paid exclusively by fee for service were planning on giving up maternity care within the next five years (55.1 per cent) than those paid through mixed payment systems (19.2 per cent), raising questions about the role of payment schemes in their decision.⁸²

Given the limited information available at a national and international level regarding reimbursement models for maternity care providers, this marks an opportunity for MOHS and BCMA to pursue research in this area and pilot innovative reimbursement models to support collaborative care.

6 a iii. Recommendations

The following physician reimbursement options are consistent with our vision of sustainable and collaborative care. In considering the options, we recognize the challenge of maintaining support for current practitioners to provide maternity care while moving the whole system toward collaborative models. Given current practices, the fee for service system will continue to be the dominant payment scheme. These recommendations are therefore offered within the context of the current system but we encourage stakeholders to continue to explore options for financing a more comprehensive women-centered, collaborative approach to care. Therefore, the recommendations are divided into short and long term strategies, recognizing the need to sustain current practitioners while encouraging new approaches to ensure the long term sustainability of maternity care by practitioners.

⁸¹ Leavey, J & Yazganoglu, E.(2003) "Physician Compensation Project; Literature Review Highlights." Ministry of Health.

⁸² Klein MC; Kelly A; Spence A; Kaczorowski J; Grzybowksi S. (2002) In for the long haul: which family physicians plan to continue delivering babies? *Cdn Fam Physician*;48:1216-1222.

Short Term Strategies

1. Continue to fund the Service Enhancement Initiative Fee.
2. Continue to fund the GP Obstetrical Incentive.
3. Develop Savings Targets Based on Clinical Guidelines.
4. Add two new fee items to the Fee for service guide, permitting physicians to bill 3 prenatal visits as counseling visits and bill 50 per cent of a prenatal visit for unrelated medical check ups which also require a prenatal check-up.

Long Term Strategies

1. Develop fee items for complex deliveries and unbundle postpartum care fees.

Although these particular recommendations may not all be implemented in the short or even longer term, we believe they provide a basis for continuing discussions between government and the BCMA. We further acknowledge that limited resources may preclude adopting all of our recommendations. Nevertheless, we would encourage discussions of their feasibility among all involved.

Recommendation #3

The Ministry of Health Services and stakeholders extend current strategies to sustain practitioners and examine long term strategies to enhance collaborative care

6 b. Valuing Other Key Maternity Care Providers

The sustainability of BC's maternity care system is based on the effective functioning of an integrated system of providers. We cannot support collaborative models of maternity care without also examining the issues facing allied providers such as midwives and nurses.

6 b i. Valuing Midwives

Planning for the maternity care workforce of the future means taking into account how we deliver maternity care services. Midwives are valuable players in the delivery of maternity care in BC, however, their ability to play an even larger role in supporting the sustainability of the maternity care system is currently limited.

Midwives are currently capped at 40 births per annum and their model of care in BC requires them to attend home births. Their scope of practice does not include vacuum delivery, surgical assistance in the case of a cesarean section, the induction of labour or other services that a family physician practicing obstetrics is able to provide. This division of practice areas serves to undermine the ability of midwives and family physicians to work together in a collaborative manner. As well, midwives are paid on a case basis rather than fee for service and are paid at a higher rate per birth compared to physicians, which has led to a degree of interdisciplinary tension between the providers.⁸³

There is great potential for midwives and family physicians to work together in a shared care model as the literature demonstrates that both providers often share a similar philosophy of care and style of practice.⁸⁴ Given the health human resource shortages BC is facing, the government needs to examine these barriers to collaboration between midwives and family physicians. Stakeholders suggested that we cannot promote sustainability without the use of collaborative care models, and unless the current barriers to practicing maternity care in an equitable manner among these two providers are dismantled, the goal of a sustainable maternity care system may be unattainable.

⁸³ Kornelsen, J. (2000). Pushing for Change: Challenges of Integrating Midwifery into the Health Care System. British Columbia Centre of Excellence for Women's Health.

⁸⁴ Payne, P & King, V.(1998) A Model of Nurse-Midwife and Family Physician Collaborative Care in a Combined Academic and Community Setting." *Journal of Nurse-Midwifery*. January/February . 43(1):19-26.

6 b ii. Valuing Nurses

Nurses are integral to the delivery of maternity care services at the hospital and community level and need to be recognized and accepted by other providers as essential partners in the delivery of maternity care. While nurses are not autonomous providers of maternity care, they provide the allied clinical skills and support to women that are central to upholding a women-centered model of maternity care.

If we are to support the development of collaborative models of care, nurses need to be included in the discussions. Given the nation-wide shortage of nurses, especially those with perinatal experience, we need to look to research which demonstrates that the recruitment and retention of nurses is improved where nurses work in supportive environments and are able to practice to the full scope of their ability based through a team-based setting.⁸⁵ Health authorities and unions should work together to ensure that collective agreements support nurses providing maternity care and provide for appropriate time and reimbursement for perinatal training.

⁸⁵ Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system – a policy synthesis. (2001). Canadian Health Services Research Foundation. www.chsrf.ca.

6 c. The Role of Health Authorities in Supporting Collaborative Care Models

Health authorities have an integral role to play in supporting women-centered, collaborative, locally-based maternity care services. For a comprehensive maternity care system to thrive, health authorities need to be intimately involved and accountable for the implementation and ongoing support of new models of maternity care delivery.

Health authorities need to support local providers to establish collaborative, team-based models of maternity care. Due to the differing reimbursement systems for the broad array of providers involved in delivering maternity care, health authorities could take responsibility for proactively initiating collaborative models of care. These team-based care models would be configured according to the availability of local resources and local capacity.

For instance, in small community and rural settings, pre-established primary health care teams could be supported to provide some level of maternity care. Obstetrical care could be offered as part of a range of primary care services delivered in a collaborative setting such as mental health services, chronic disease services and other primary care support services.

Health authorities could solicit local provider interest, initiate and operate a maternity care clinic out of a local hospital or community health centre for a “one-stop shopping” model of care. These maternity care services could be piloted in various communities throughout a region. The health authority could be responsible for providing the clinic with fiscal support for overhead, including the coverage of administrative support expenses and the installation and maintenance of information technology systems.

For example, the Interior Health Authority provided financial support to Penticton Regional Hospital to set up a Family Practice Maternity Service within the hospital. The estimated start-up cost was \$70,000 to renovate clinic space, with ongoing annual costs estimated at \$50,900 for administrative and information technology support.⁸⁶ In-kind contributions at this site included:

- Office and waiting room space in the hospital to house the program’s services.
- Access to labour & delivery suites at PRH.

⁸⁶ Creating a Sustainable Future for Maternity Care in the South Okanagan: A Proposal for Primary Maternity Care Services at Penticton Regional Hospital. Interior Health Authority, May 2004.

- Resources, such as meeting space, for staff planning and educational sessions.
- Support and technical assistance from IHA's Information Technology Department to develop a long-range IT strategy, along with ongoing technical and educational assistance once an IT system is installed and operational.

Health authorities could also take a leadership role in supporting collaborative maternity care by soliciting stakeholder input and developing community-based maternity care networks, based on a shared philosophy of care, where maternity care providers can support and learn from each other.⁸⁷ An effective network would:

- Provide ongoing professional advice to providers.
- Support vehicles for good communication between professionals, such as computerized medical records.
- Provide clear and consistent advice on key clinical topics.
- Develop a common risk management strategy.
- Develop common protocols and guidance related to risk assessment and management.
- Create multidisciplinary maternity forums to explore issues and share knowledge.
- Establish "emergency drills" through which providers can explore and rehearse responses to critical incidents.
- Instigate processes of audit to monitor, assess and evaluate practice.

Finally, health authorities could examine the possibility of funding doula services within the context of a hospital or community health centre-based primary maternity care service. An example of this kind of health authority support currently operating is the South Community Birth Program, where doulas have been funded by the Provincial Health Services Authority through Primary Health Care Transition Funds.⁸⁸

PHSA supported the funding of doulas for this maternity program because research demonstrates that continuous support from a doula improves outcomes for expectant mothers, including shorter labours, less need for pain medication, a reduced likelihood of having a cesarean delivery and healthier babies.^{89 90}

⁸⁷ Grzybowski, S., & Kornelsen, J. (work in progress). What are the components of a sustainable rural maternity care system? Recommendations for policy and practice, September 2004.

⁸⁸ South Community Birth Program. www.scbp.ca

⁸⁹ Hodnett ED. (2002) Caregiver support for women during childbirth. Chchrene Database Syst Rev. (1):CD000199.

Recommendation #4

Health Authorities support the implementation of collaborative models of maternity care at the regional and local level.

⁹⁰ Hodnett ED. (2002) Pain and women's satisfaction with the experience of childbirth: a systematic review. *Am J Obstet Gynecol.* 186(5 Suppl Nature):S160-72.

6 d. Promoting Collaboration through Education

Teamwork has a long tradition in health care and considering the health human resource shortages the health system is facing, promoting teamwork for primary maternity care among nurses, midwives, family physicians, GP surgeons and anaesthetists and obstetricians is an important goal. However, education for teamwork will be vital for the entire range of people working in maternity care if collaborative models of care are to succeed.

Good teamwork is also an essential component of women-centered maternity care. During the MCEP consultation process, stakeholders supported the need to promote collaborative approaches to the education of maternity care providers at the undergraduate, graduate and continuing education levels.

One definition of interprofessional education is health care providers learning together to promote collaborative care. This approach to collaboration among several professions during the learning process may:⁹¹

- Provide health care providers opportunities to work together, using shared problem solving and collaborative decision making;
- Develop mutual understanding and respect for the contributions of various health care providers;
- Instill in providers the necessary competencies for collaborative practice.

In order to support sustainable models of maternity care, MCEP stakeholder suggestions were in line with SOCG recommendations which propose that:⁹²

- Educational programs incorporate interdisciplinary learning;
- Overlapping areas of competency should be recognized and taken advantage of;
- Providers should be willing to teach learners from all disciplines in order to provide consistent, positive role models.

Research on interdisciplinary education demonstrates that a collaborative approach to education promotes a team attitude toward

⁹¹ Interprofessional Education for Collaborative Patient-Centered Practice: A Health Canada Initiative. (2004) Health Canada.

www.eicp.ca/en/resources/pdfs/Interprofessi.pdf

⁹² Society of Obstetricians/Gynecologists of Canada. (2001) *Recommendations for a Sustainable Model of Maternity and Newborn Care in Canada.*

problem management.⁹³ In fact, research demonstrates that the benefits of interdisciplinary education lead to improved patient outcomes as well as affording the various professions involved an opportunity to gain greater understanding and respect for each others role as health care providers.⁹⁴

A focus on teamwork could include more interdisciplinary and shared care courses in initial education programs, as well as more training on working in collaborative teams. Physicians, nurses, midwives and other health care providers working in obstetrics require many of the same skills and competencies in their training. The enhancement and promotion of further interdisciplinary educational opportunities could facilitate a shared understanding of obstetrical care and foster joint working relationships and collaboration between all parties. For example, Managing Obstetrical Risk Efficiently (MORE^{OB}) is an educational program that assists multidisciplinary maternity care providers in building and sustaining team-based care. The program also encourages team-based learning, training and communication that can affect change in the model of care.

In some cases, stakeholders noted that current educational programs do not meet the needs of maternity care providers, especially those located in rural and remote communities. Due to the shortage of physicians, midwives and nurses in these rural communities, a lack of locums, casual nursing staff and a lack of funding, providers in rural communities have limited ability to participate in continuing medical education events. Training programs need to be offered in formats that meet the needs of providers and be made available as close to a provider's home community as possible. For example, stakeholders from rural areas noted that the British Columbia Institute of Technology's Perinatal Specialty Program format and content does not meet the needs of rural nurses.

Stakeholders and the research suggest we also need to establish more education programs that encourage providers to maintain and upgrade their skills to meet the needs of women and their local communities. For example, rural practitioners need access to educational programs that teach them the advanced skills they require to help them build

⁹³ Symonds I; Cullen L; Fraser D. (2003) Evaluation of a formative interprofessional team objective structured clinical examination (ITOSCE): a method of shared learning in maternity education. *Med Teacher*. 25(1):38-41

⁹⁴ Singelton JK, Green-Hernandez C. (1998) Interdisciplinary Education and Practice: Has Its Time Come? *J Nurse-Midwifery*. January/February. 43(1):3-7.

their confidence to practice maternity care in small or remote communities.⁹⁵

There is a need to aggressively promote and support training for maternity care providers at the undergraduate level. One stakeholder suggested that rural maternity care could be better sustained through the development and recognition of a formalized training program for Family Practice Obstetrics. This designation would offer graduates qualifications that are portable throughout rural Canada so that communities in need have access to skilled personnel.

MCEP participants agreed that we need to develop a plan to support a variety of collaborative approaches to the education of maternity care providers. Elements that would need to be covered in such a plan would include:

- Supporting interdisciplinary education;
- Providing continuing training and education for maternity care providers through innovative means, such as through the use of telehealth technology;
- Ensuring educational programs are accessible in both in-house and outreach formats.

BCRCP was created to facilitate and support the ongoing regionalization of perinatal care within BC. This role includes liaising with providers and institutions, promoting and facilitating interdisciplinary outreach education, developing guidelines for care and service delivery, promoting perinatal care networks and collecting and analyzing perinatal data to evaluate outcomes. This report marks an opportunity for BCRCP to broaden its role to include the support of women-centered, collaborative care models as well as quality maternity care services and lead the development of a plan to support collaborative approaches to maternity care education.

⁹⁵ College of Family Physicians of Canada (1999). Society of Rural Physicians of Canada, Society of Obstetricians and Gynaecologists of Canada. Training for Rural Family Practitioners in Advanced Maternity Skills and Cesarean Section. Joint Position Paper.

Recommendation #5

The Ministry of Health Services supports the development of a coordinated, comprehensive provincial maternity education plan for all maternity care providers at undergraduate, graduate and continuing education levels.

***Maternity care is a partnership
among women, providers and
communities to ensure that
BC's children get the best
possible start in life.***



Next Steps

This report concludes an extensive consultation and research process to address the sustainability of maternity care services in British Columbia which arose from the 2004 Working Agreement between the BCMA and MOHS. However, the multidisciplinary group of stakeholders who provided input and direction for the work and recommendations presented in this report agreed that further work needs to be undertaken to support the development of a women-centered, integrated and sustainable system of maternity care.

7a. A Provincial Approach to Quality Maternity Care

The high attrition rate of physicians providing obstetrical care is resulting in a lack of peer support among the remaining providers. For example, providers from rural areas noted a lack of local expertise on which to consult on issues of risk management and care should a pregnancy or intrapartum experience result in complications or end with a poor outcome.

In order to support better practices among providers, MOHS should commit to establishing a provincial approach to quality in maternity care services. For example, functional collaboratives could be created among providers that offer caregivers a safe forum to discuss care practices, examine innovative ways to work together in shared care teams' and assist providers in seeking to improve the health of women and their babies. Collaborative learning activities bring together health care organizations and providers who share a commitment to making major, rapid changes that produce breakthrough results: lower costs and better outcomes for patients. An excellent example of this is the MORE^{OB} program developed by the SOGC to support the use of this kind of methodology in labour and delivery settings.

Several participants in this consultation also suggested that a provincial approach to mortality (and potentially morbidity) review would assist all providers in understanding how to reduce risk and improve quality of care. Provincial maternal mortality reviews exist in other jurisdictions and their legislation and structures could be reviewed in support of a similar provincial process in BC.

Responsibility for such a provincial process could be added to the mandate of the BCRCP.

Recommendation #6

The Ministry of Health Services commit to a provincial approach to support quality in maternity care services that includes the formation of formal collaboratives among providers and the review of mortality and morbidity outcomes.

7b. The Need for Continued Dialogue

There are significant gaps in our knowledge regarding the delivery of maternity care services. For example, more research needs to be conducted about what women want from their maternity care services if we are to develop a truly women-centered service. We also need more research into the impact of collaborative care models on providers, women and the health care system as a whole. These models of care are recent initiatives and have not been effectively evaluated to understand their impact on maternity care delivery. Detailed work will also need to be initiated to comprehend the workforce implications of the guiding principles set out in this report.

The Maternity Care Enhancement Project has been a fruitful process that brought together a multidisciplinary group of stakeholders to discuss and envision a sustainable future for maternity care in BC. There is a need for dialogue to continue over the next year in order to reap the benefits from this process and monitor the progress and implementation of the recommendations in this report.

Recommendation #7

The Ministry of Health Services establish a process to monitor and ensure the progress and implementation of the recommendations in this report.

***The future of high quality
maternity care services lies in
the development of women-
centered, integrated, locally-
based models of care.***



Summary of Recommendations

This chapter brings together the work of the MCEP consultation and research process and demonstrates how the recommendations fit together to create an overall strategy to develop women-centered, integrated, local solutions for sustainable maternity care in British Columbia.

All of the recommendations are based on the philosophical approach to maternity care service delivery outlined in the guiding principles. Due to the numerous suggestions put forth by stakeholders during this process, we have only listed the recommendations that stakeholders felt were a priority issue to tackle in order to move towards the development of a sustainable care system.

The recommendations represent a summary of the priority suggestions brought forth through the consultation process and demonstrate the intense effort put into this project and the exceptional contributions made by all stakeholders.

Maternity Care Enhancement Project Recommendations

Recommendation #1

The Ministry of Health Services support the development of a women-centered maternity care pathway for British Columbia.

Recommendation #2

The Ministry of Health Services promote and support women-centered, collaborative, team-based service models among all maternity care providers.

Recommendation #3

The Ministry of Health Services and stakeholders extend current strategies to sustain practitioners and examine long term strategies to enhance collaborative care

Recommendation #4

Health Authorities support the implementation of collaborative models of maternity care at the regional and local level.

Recommendation #5

The Ministry of Health Services supports the development of a coordinated, comprehensive provincial maternity education plan for all maternity care providers at undergraduate, graduate and continuing education levels.

Recommendation #6

The Ministry of Health Services commit to a provincial approach to support quality in maternity care services that includes the formation of formal collaboratives among providers and the review of mortality and morbidity outcomes.

Recommendation #7

The Ministry of Health Services establish a process to monitor and ensure the progress and implementation of the recommendations in this report.