SUMMARY REPORT | NOVEMBER 2024

Team-Based Perinatal Care Snapshots

In Collaboration with Shared Care Committee Perinatal CoP, Perinatal Services BC and Midwives Association of BC

SharedCare Partners for Patients

Perinatal Services BC
Provincial Health Services Authority

MIDWIVES ASSOCIATION of BRITISH COLUMBIA

doctors of bc

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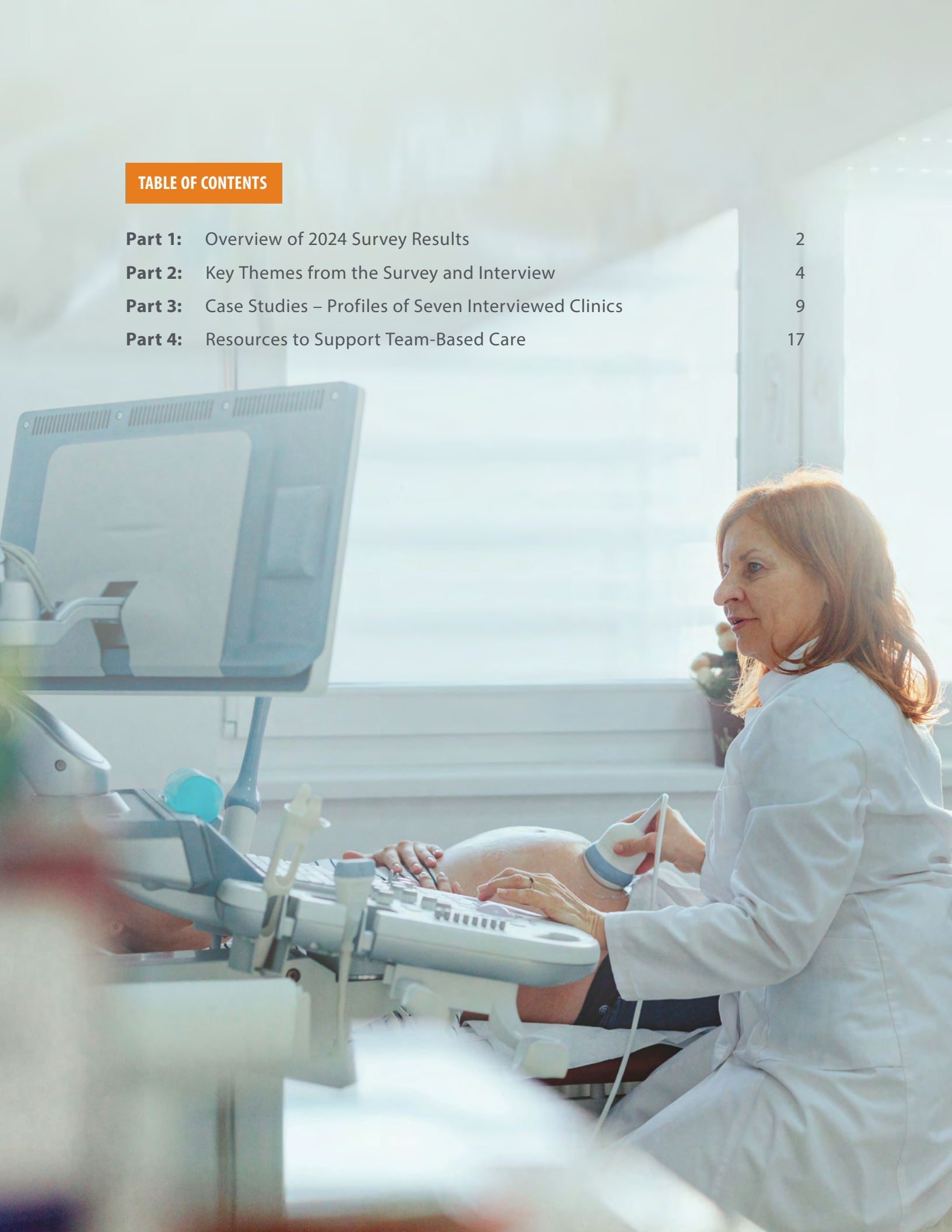


Overview

Maternity care providers in British Columbia are struggling to provide service across the province. Many of our maternity providers have felt the need to move into multidisciplinary teams to have sufficient health human resources to be able to continue to provide maternity care. We have heard multiple requests to provide information on how to work through the logistics of developing a multidisciplinary team. In response to these requests, the Shared Care Committee Perinatal Community of Practice, Perinatal Services BC and the Midwives Association of BC have joined forces to engage a working group to provide a snapshot of how such clinics have developed around the province.

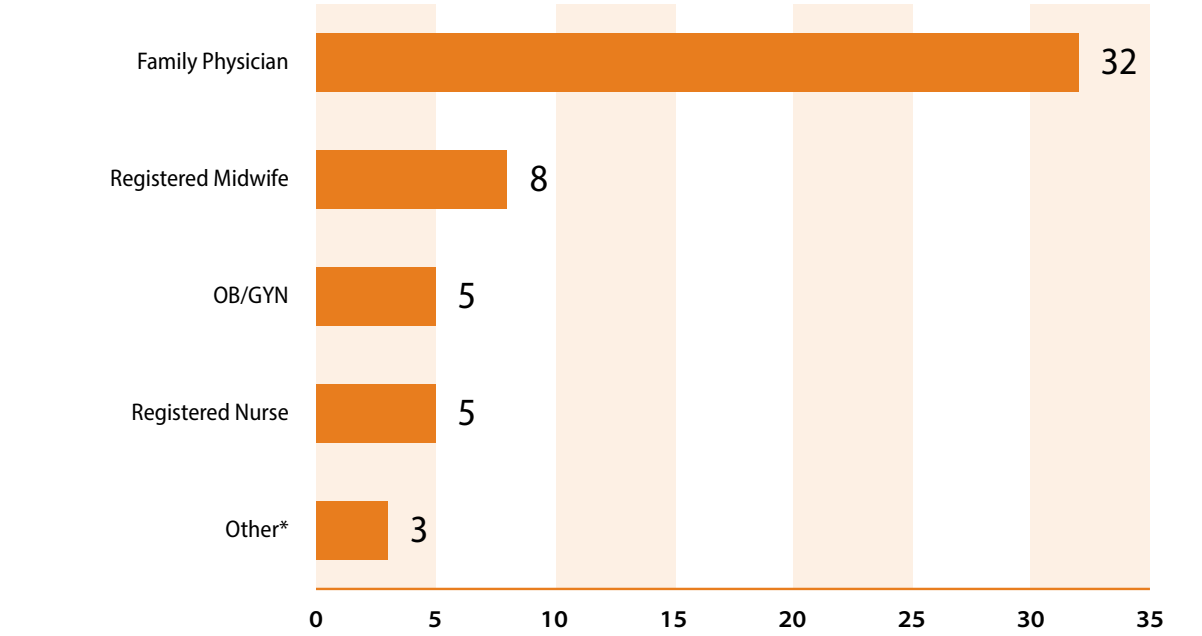
The document provided is not a detailed toolkit of "how to" but rather a snapshot of how things have been done in various clinics around the province. The survey and snapshot themes have been divided into how to get started; funding models; shared resources; and communication and shared values. Following that are the practice profiles with a contact information, should you wish to find out further details from a specific practice.

What we learned is that there is a great variation in how the clinics have been developed, and what works to meet the needs of different communities. Few clinics would change the model that they are currently working in, but all had suggestions for improvements. Developing a common vision and a governance model as part of the initial steps is of utmost importance.

Findings from the maternity care provider survey conducted by PSBC in 2023 highlighted the significant concerns that health care providers had about the stability of services. Fifty-six percent of respondents reported that services were not stable in their area and described frequent site closures, shortages of all perinatal and newborn care providers, long patient wait lists and an increasing number of unattached patients. When asked what their plans were for the next two years, 60% of respondents reported plans to reduce their on-call hours and 31% planned to leave maternity services.

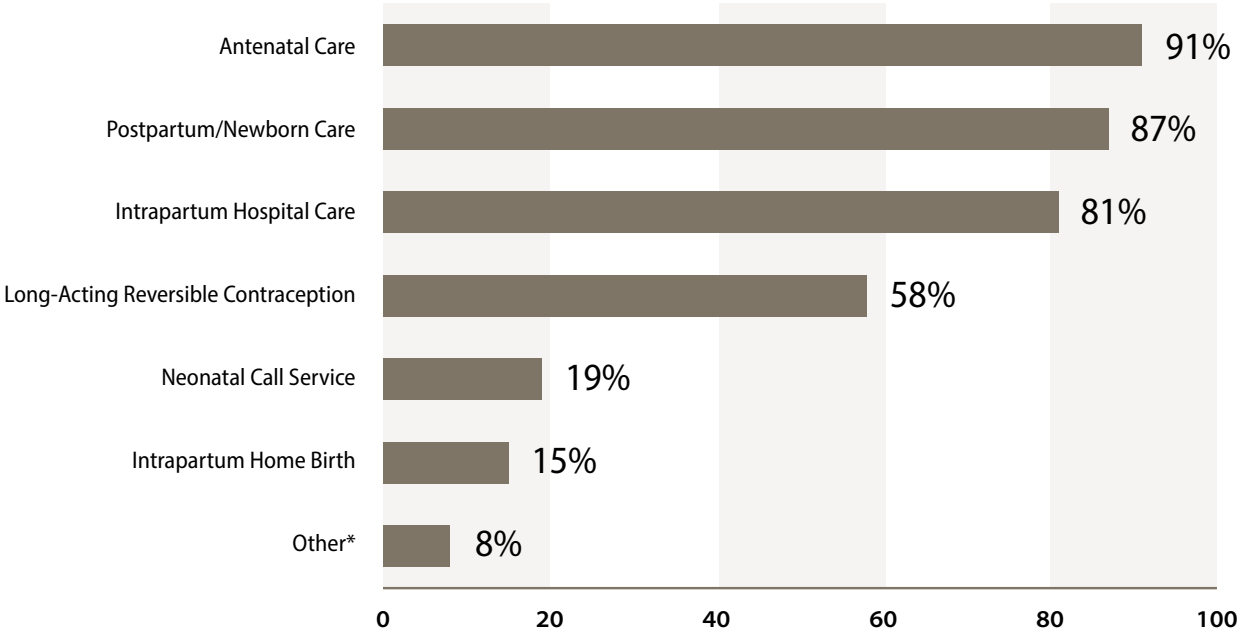
PART 1
Overview of 2024 Survey Results

ROLE OF RESPONDENT



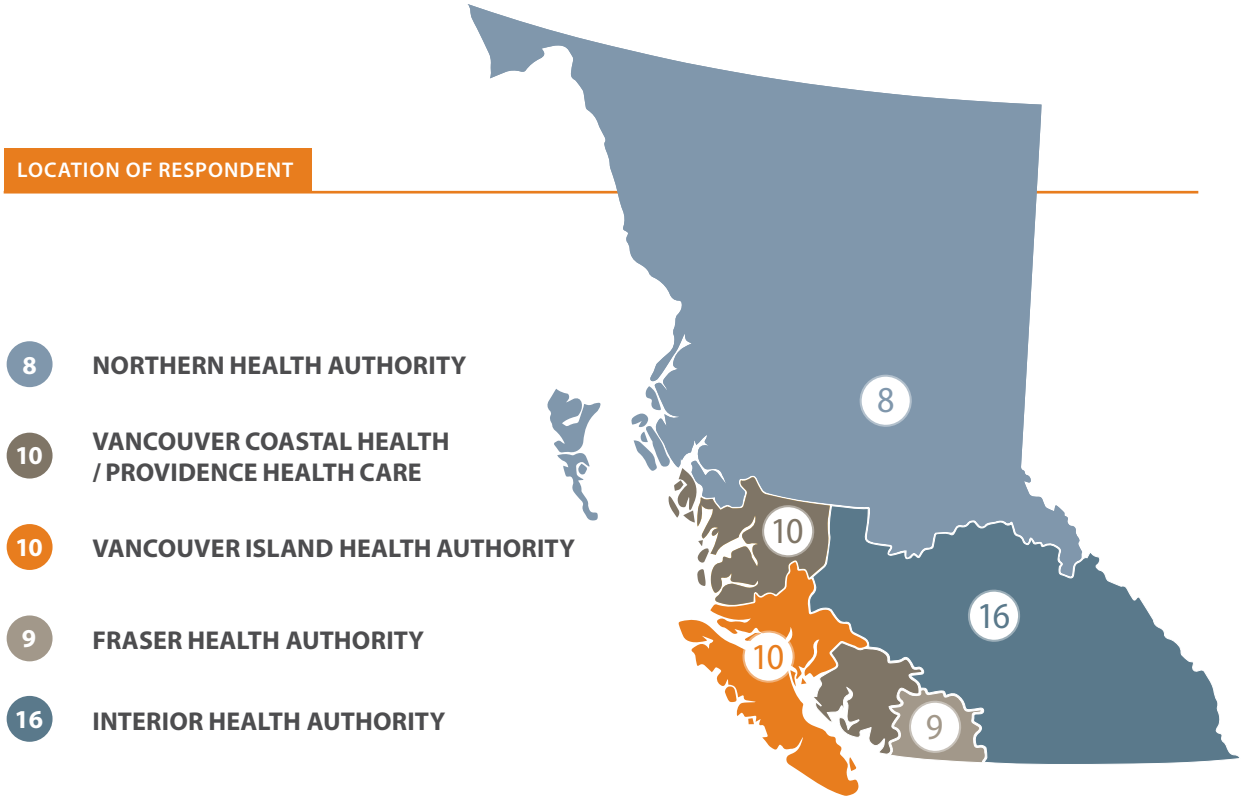
*Other includes physiotherapist, dietician, community services manager

SERVICES

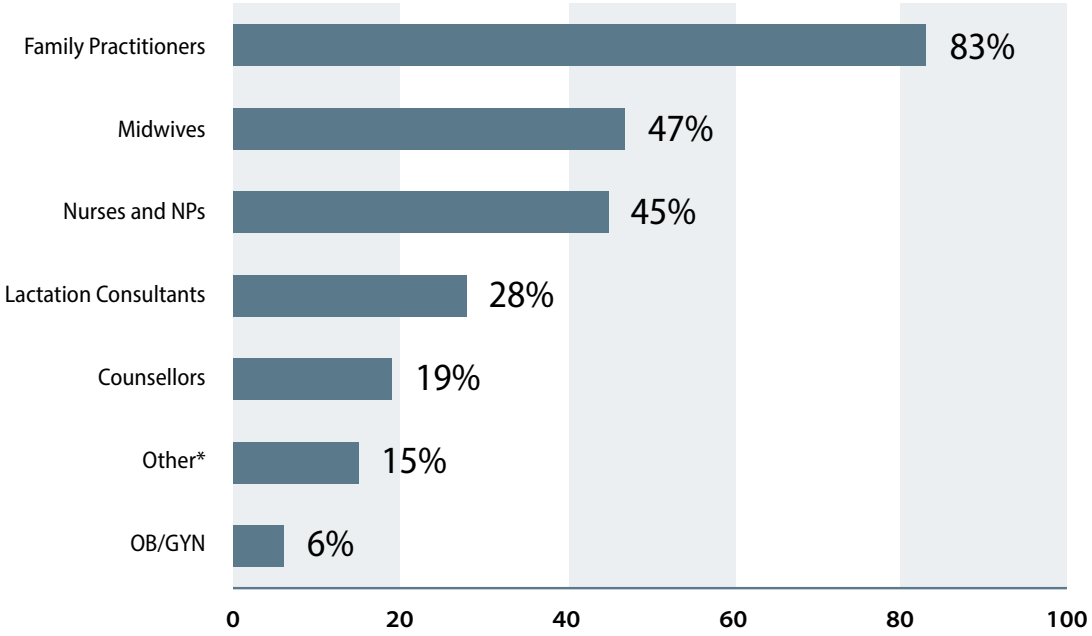


*Other includes gynecology services, lactation consultation, and ongoing baby care for families without a primary care provider

LOCATION OF RESPONDENT



TEAM COMPOSITION



*Other includes physiotherapy, massage therapy, Indigenous liasion, social work, complex care coordination, pregnancy education facilitation, clinical pharmacy, dietetics, psychiatry, pediatrics

PART 2

Key Themes from the Survey and Interview

Getting Started

Establishing a new clinic was often done based on the needs of the community and in the face of other struggling practice models (e.g., difficulty staffing, fewer providers doing maternity as part of their practice, pandemic-era challenges).

Providers sometimes worried prior to establishing a team-based clinic about how prospective patients might respond to a model of care that includes both physicians and midwives. Their concerns were generally unfounded – interviewees reported overwhelmingly positive feedback from families.

SURVEY

45% of respondents reported their clinic had been in operation for at least 10 years.

- "We built the clinic out of necessity. There was a midwifery team and a family physician team, and it wasn't sustainable for either of us. It was also done out of needs of the community; a patient journey mapping done through the Divisions of Family Practice showed there were notable gaps in care for lactation and perinatal mental health."
  Tanya Momtazian RM – Appletree Maternity

- "There was some initial concern that people would only want to see a midwife, but that hasn't materialized. The feedback we're getting is that people are very happy and grateful to have access to a midwife and physician."
  Ariel Christman RM – Selkirk Medical Group

- "Starting off, we didn't know anyone who was doing this, so we had to figure it out all at once. How do you hire a nurse? What do you pay them? What kind of contract do you have? What do you offer them?"
  Alicia Power MD – Grow Health

- "We started off with three midwives and three doctors, doing 75 births a year, only a few years after midwifery was legalized so it was initially a hard sell, mostly to other midwives and physicians."
  Lee Saxell RM – South Community Birth Program

SURVEY

Nearly half of respondents said their practice currently cares for more patients than the group had planned for when the practice was established.

Funding Models

Multiple interviewees and survey respondents emphasized the need for a universal billing structure that supports team-based models and allows physicians and midwives to be paid in the same way.

Teams reported that there wasn't a clear model for how to bill in a team-based practice. When starting out, some spoke to existing team-based clinics for advice on how to compensate different types of providers; others figured it out as they went along. Figuring out how to appropriately bill can be a source of stress for providers and can consume a disproportionate amount of administrative time. The introduction of the Longitudinal Family Physician (LFP) payment model has led to questions about how it should be used in practices with different types of professionals.

SURVEY

59% of respondents reported that their clinic had no ongoing external funding for operational costs.

- "There isn't a perfect billing model that fits collaborative care at the moment."
  Lauren Baerg MD – Cedar House Collective

- "We had initially applied for some PCN funding in the hopes of having a social worker and counsellor. But because of the definitions of longitudinal care and maternity care not fitting into that, we didn't get it, despite a change request application."
  Lauren Baerg MD – Cedar House Collective

- "We have five nurses working at SCBP, for a total of three FTEs. We have been approved for two FTEs through the Nurse in Practice program but still waiting for funding. This funding is really exciting because it recognizes clinics doing only maternity care"
  Lee Saxell RM – South Community Birth Program

- "Currently our prenatal and postnatal care is more complicated with introduction of LFP billing, which the midwives cannot access."
  Courtney Rennie MD – Selkirk Medical Group, via survey response

- "One advantage of the LFP model is that we can build in a bit of paid administrative time for business and decision-making meetings."
  Alicia Power MD – Grow Health

- "Women seen in this clinic are unattached and often very complex and more time is needed for each appointment. Fee for service is not appropriate for this clinic."
  Shelley Movold, Community Services Manager – Prince George Urgent and Primary Care Centre, via survey response

- "We need sustainable funding for allied health (we currently have grant from Ministry of Health via the BCAHC but have to apply every year and there is a delay)."
  Tanya Momtazian RM – Appletree Maternity, via survey response

- "We had roundtable discussions and came up with something where everyone felt like their time was fairly compensated for each specific type of interaction."
  Ariel Christman, RM – Selkirk Medical Group

- "If we had midwife specific codes that matched LFP, then that would make billing easier. Everyone could use their own LFP codes, and we wouldn't have to do this really time-intensive divvying up of this internal fee schedule from lump sum billings."
  Ariel Christman RM – Selkirk Medical Group

Shared Resources (Physical Space and EMR)

Nearly all clinics used some type of EMR but there was substantial variation in interconnectivity – some practices could access other data systems (e.g., Health Authority) through their EMR; some had multiple separate EMR platforms for different providers within the team.

Teams reported various pros and cons to receiving Health Authority funding vs. operating as a private practice. Health Authority-supported clinics reported spending less money on office space and less time on running a business. Clinics run as private practice reported that having control of staffing (e.g., hiring and firing) was worth the extra time spent on administrative work.

SURVEY

58% of respondents were based in community; 42% were based in hospital.

- "Our biggest problem right now is clinic space. We could easily double or triple our square footage and it still wouldn't be enough room."
  Liz Grose RM – Cedar House Collective

- "The challenge with all EMRs including ours [Profile IntraHealth] is that it's not made for team-based care. There are no discussion boards and there's no way to have a full roster of all our due dates and information within the EMR, so we end up using several outside spreadsheets."
  Tanya Momtazian RM – Appletree Maternity

- "The lack of an EMR creates a lot of extra work as well as huge potential for things to be missed which worries me."
  Shana Johnston MD – Victoria General Hospital AAU Prenatal Services Clinic, via survey response

- "I wouldn't say everyone's terribly happy with MedAccess but because there are so many physicians in the group, I'm not sure we're going to make a change. It would be a big deal to move to something different."
  Ariel Christman RM – Selkirk Medical Group

- "A downside of our current model [PCN funding for nurses] is that we have much less control over hiring. We weren't even able to include knowing about pregnancy or lactation as requirements in the job posting. [The nurses] are seen as part of the integrated team and work in the building but they're managed by the Health Authority. If there were a situation where they're doing something that's not in alignment with how we work, we have no control to change that. It's nice that we don't have to figure out how to pay nurses and figure out the logistics on our own, and luckily the people we've had have been phenomenal. But there's huge potential for it to not go well."
  Alicia Power MD – Grow Health

- "We can see care from anywhere in Fraser Health through our EMR, which is really useful."
  Amelia Doran RM – Seabird Island First Nation Health Centre

- "We could use more space for collaboration with public health lactation consultants"
  Jaco Strydom MD – Women Wellness Clinic, via survey response

Communication, Relationships, and Values

Mutual respect and an appreciation for the work of other types of professionals were mentioned as core values.

The Rural Coordination Centre Coaching program of British Columbia was highly recommended as a way for teams establishing a new practice to outline how they will collaborate. Several teams met with a coach before they began working together and had a workshop about stress management, communication, and conflict resolution. They reported that it was a valuable way to develop a consensus-based approach to decision-making.

Many interviewees mentioned having drawn up foundational documents (e.g., agreements, governance structures) either with a lawyer or via committee when establishing their clinics. These agreements were then revisited and revised as needed every few years. Teams recommended developing clear and specific communication guidelines, such as when to call one another, what information should be shared via email vs. text, and standards for charting.

- "If you're going to be doing something new and practicing in a new way, having initial coaching support before you start working together clinically sets the stage for what things are going to look like and allows you to thrive, even amidst conflict."
  Lauren Baerg MD - Cedar House Collective

- "We all have huge respect for what each occupation brings to the model."
  Liz Grose RM - Cedar House Collective

- "Everyone wants to go straight to the money aspect but it's important to ask 'how are you going to work together? What's your philosophy of working together, of caring for patients and families? What happens if there's conflict?'"
  Tanya Momtazian RM – Appletree Maternity

- "[The SCBP shift model] builds great camaraderie because you know there is always someone to support you and cover for you"
  Lee Saxell RM - South Community Birth Program

- "We did the RCCBC Quality team coaching initiative, which was excellent and really helped us reiterate our team values and philosophy. We added our nurses and allied health into the conversation."
  Tanya Momtazian RM - Appletree Maternity

- "We started talking as a group: what are people's career aspirations and career goals? What were they hoping to get out of this? What wasn't working well for them in their current [non-interdisciplinary] model?"
  Ariel Christman RM - Selkirk Medical Group

- "In terms of call [as a midwife working with physicians], we had the conversation of 'what were my needs in terms of who needs to be on call for me? What does working at full scope look like?' We went through that conversation about Discussion Consultation Transfer guidelines."
  Ariel Christman RM – Selkirk Medical Group

- "Be very clear on how you're going to be running the practice. Is everyone an equal partner? How are you going to make decisions? Is it going to be based on consensus? Is it going to be majority? It's important to think about those pieces, even though we don't necessarily get training on this as healthcare providers."
  Alicia Power MD - Grow Health

- "Every six weeks we have the whole team for a Lunch and Learn, to eat together and discuss a topic as a group."
  Alicia Power, MD, Grow Health

PART 3

Case Studies – Profiles of Seven Interviewed Clinics

CASE STUDY

Profile 1

Clinic Name	Appletree Maternity
Interviewee Name	Tanya Momtazian, Registered Midwife
Location	Nelson (Interior Health)
Years in Operation	10
Staffing	Four midwives, two family physicians, two RNs/lactation consultants, one psychiatric nurse, two social workers, two prenatal educators, two medical office assistants
Shared Space	Yes, in community health centre (rent is highly subsidized)
EMR	Profile IntraHealth
Volume	180-200 births per year of the 240-260 births at Kootenay Lake Hospital.
Home Births	Yes, done by both family physicians and midwives.
Billing	LFP; MSP mostly with midwifery billings, pool billing for births and distribute them per call shift or sessional hour.
Start-up Funding Sources	None. Used small business loans and individual corporations to invest their own money initially. Applied for grants but we didn't get any and didn't want to wait.
Ongoing Funding Sources	Grants through the BC Association of Health Centres for lactation support and perinatal mental health programs. Medical On Call Availability Program (MOCAP).
Strengths	▶ Model of practice, team composition, and services to meet the needs of the community. ▶ Team is highly supportive of one another and their families.
Barriers	▶ No access to allied health support through the PCNs or from Nurse in Practice program. ▶ Administrative burden (hiring, etc.) takes time and effort compared to a practice housed within a Health Authority. ▶ Rural communities: communication and billing can be challenging if someone is getting prenatal care in a remote community but planning to come to Nelson to deliver.
Things They Would Have Done Differently	▶ Be more explicit in terms of team philosophy and values from the beginning. ▶ Had more conversations with community, especially public health, because sometimes they felt a little bit out of the loop in terms of communication. Communication is generally more with the hospital.
Contact	appletreematernity@gmail.com

CASE STUDY

Profile 2

Clinic Name	Cedar House Birth Collective
Interviewee Name	Lauren Baerg, Family Physician and Liz Grose, Registered Midwife
Location	Courtenay (Island Health)
Years in Operation	1 year (started March 2023)
Staffing	Six midwives, five family physicians
Special Populations/Services	Addiction medicine; rapid access family physician appointments for individuals with no GP.
Shared Space	Yes, in community, privately leased space
EMR	OSCAR
Volume	20 births per month (240 per year of the 550-600 deliveries in Courtenay)
Home Births	Yes, but only the midwives in the practice as primary (family physicians attend as secondary).
Billing	Whoever does delivery bills MSP accordingly (Midwifery intrapartum code for midwives, MSP fee for service for most physicians, one on LFP). Occasional billing of MD codes for things outside of the scope of midwifery practice. Pool billings and pay each other out of the pool based on time worked in clinic and on call.
Start-up Funding Sources	None
Ongoing Funding Sources	Recently approved for Nurse in Practice funding to hire a nurse for the clinic – through a subset of the Nurse in Practice program specific to focused family practice clinics (includes maternity and doesn't have requirements around patient attachment). Will soon receive MOCAP for being the provider on call for unattached patients in the community.
Strengths	▶ Huge enthusiasm and interest from providers in working in this collective model of collaborative practice
Barriers	▶ Initial hesitation from other area practices about how the new clinic would change patient volumes and locum availability for existing midwifery and family practice maternity clinics. ▶ Clinic space is too small given the number of providers and patients
Things They Would Have Done Differently	▶ Set up in bigger space right from the start. At the time it felt too financially risky to choose a bigger space, not knowing how the Collective would be received by the community and what sort of funding they would get for allied health.
Contact	info@cedarhousebirthcollective.com

CASE STUDY

Profile 3

Clinic Name	South Community Birth Program
Interviewee Name	Lee Saxell, Registered Midwife
Location	Vancouver (Vancouver Coastal Health)
Years in Operation	22
Staffing	Family Physicians, Midwives, Nurses and Nurse Practitioners, Lactation Consultants, Counsellors (25 providers in total)
Special Populations	Focus on marginalized populations, new immigrants and refugees
Shared Space	Yes, in community (attached South Hill Health Centre-Primary Care)
EMR	OSCAR
Volume	700 births per year
Home Births	No
Billing	Pooled billings
Start-up Funding Sources	Federal Primary Care Transition Funds in 2000
Ongoing Funding Sources	Nurse in Practice program (have not yet received them)
Strengths	▶ South Community Birth Program's shift work model is very appealing to providers. Allows providers to have more work-life balance and get coverage easily in case of illness, etc. ▶ The program serves a very diverse patient population – varied, rewarding work for the clinical team. ▶ Large team of support workers who provide translation and doula services. In house OB consultant, pediatrician and lactation consultant. Launching a Community Health Worker position in 2025.
Barriers	▶ Recruitment: compensation models for midwives and physicians have led to a widespread shortage of providers doing intrapartum care.
Things They Would Have Done Differently	▶ Included OB and Peds consultants earlier for more one-stop shop care.
Contact	office@scbp.ca

CASE STUDY

Profile 4

Clinic Name	Sunshine Coast Maternity Care Group
Interviewee Name	Rayna Sidvakova, Family Physician
Location	Sunshine Coast – Langdale to Pender Harbour (Vancouver Coastal Health)
Years in Operation	4
Staffing	Five family physicians and two midwives
Shared Space	No, all the providers work out of their own offices in the community
EMR	Not shared. Each location has their own system (OSCAR, Med Access). Records are sent to hospital by fax.
Volume	150-180 deliveries per year
Home Births	Yes, led by midwives
Billing	Each provider bills according to own office. Pooled billing for on-call work that are distributed once per month based on the number of shifts worked.
Start-up Funding Sources	Shared Care
Ongoing Funding Sources	Rural Obstetric and Maternity (ROAM) Sustainability Program. MOCAP funds for both physicians and midwives
Strengths	▶ Strong team culture and collaboration
Barriers	▶ Distance: the practice serves patients from all over a 120km stretch of the Sunshine Coast. ▶ Different billing structures for different types of providers
Things They Would Have Done Differently	▶ Have a shared EMR ▶ Consider having the maternity clinic located within a hospital rather than spread across different clinic sites.
Contact	info@scdivision.ca

CASE STUDY

Profile 5

Clinic Name	Selkirk Medical Group
Interviewee Name	Ariel Christman, Registered Midwife
Location	Revelstoke (Interior Health)
Years in Operation	3
Staffing	Two maternity groups, each includes four family physicians, one midwife. One of the groups has OSS and ESS (Obstetric and Enhanced Surgical Skills for family physicians), and one is a family practice anesthetist (FPA).
Shared Space	Yes, in community. Building owned by primary clinic team.
EMR	MedAccess. Not connected to other sites.
Volume	More than 100 births per year
Home Births	No, only one midwife, not feasible for her to do home births solo
Billing	Pooled MSP billing. No LFP billing. Physician billing codes for contraception, etc.
Start-up Funding Sources	Shared Care
Ongoing Funding Sources	ROAM, More OB More EX, MOCAP
Strengths	▶ Model of practice allows midwives to work at full scope. ▶ Team is supportive of each other's personal and professional goals, allows for adequate time off.
Barriers	▶ Ensuring that administrative staff are feeling confident about how to bill for different interactions, in a timely manner
Things They Would Have Done Differently	▶ Nothing!
Contact	heartwoodmidwifery@gmail.com

CASE STUDY

Profile 6

Clinic Name	Grow Health
Interviewee Name	Alicia Power, Family Physician
Location	Victoria (Island Health)
Years in Operation	9
Staffing	Four family physicians (maternity and longitudinal family practice), three general pediatricians, two pediatric endocrinologists, two nurses, one mental health and substance use worker (0.5 FTE), one social worker (0.2 FTE)
Special Populations/Services	Long-Acting Reversible Contraception (LARC) for family practice and maternity patients
Shared Space	Yes, in the community, privately leased space
EMR	OSCAR
Volume	200 births per year
Home Births	No
Billing	LFP for family physicians; Nurses are paid through PCN
Start-up Funding Sources	Self-funded by founders
Ongoing Funding Sources	PCN for nursing
Strengths	▶ Co-location with pediatricians and pediatric endocrinologists allows for informal consultation and collaboration. ▶ Consistent vision, care, and messaging across the different team members and professions
Barriers	▶ Cost of living in an expensive city is a barrier when hiring. ▶ Would be great to have a "new to practice shared experience" for recent residency graduates in family medicine. Create a model that allows people to get a feel for the joys of longitudinal model maternity care, but also give them the flexibility that a lot of new providers want at that stage of their career (to have children, travel, etc.)
Things They Would Have Done Differently	▶ Be very clear right from the start on how practice will be run, how decisions will be made. ▶ Seek out leadership training and support for how to run a business ▶ Have conversations about communication best practices (e.g., when to text vs. email).
Contact	aliciapower78@gmail.com

CASE STUDY

Profile 7

Clinic Name	Seabird Island First Nation Health Centre
Interviewee Name	Amelia Doran, Registered Midwife
Location	Agassiz (Fraser Health)
Years in Operation	12
Staffing	One to two midwives and two maternal/child health nurses
Special Populations	Members of Seabird Island First Nation and nine surrounding bands; young parents.
Shared Space	Yes, located in the health centre for the First Nation, along with two non-maternity family physicians, and other services (diabetes care, substance use support).
EMR	Profile, connected to Fraser Health
Volume	40-60 deliveries per year
Home Births	No, as back-up coverage is unavailable. Limited demand for home birth in the community.
Billing	Midwife is on contract with Seabird Island First Nation. Bills MSP (midwife codes) plus top up from band and top up from FNHA to ensure consistent salary each month regardless of number of births.
Start-up Funding Sources	Original contribution from FNHA (practice established around the same time as FNHA) in recognition of the fact that a lot of the work is non-billable.
Ongoing Funding Sources	Perinatal Substance Use project funding, BCAPOP
Strengths	▶ Clinic provides consistent care in the community and patients don't have to travel for appointments. Maternity is co-located with other health and community services. ▶ Communication with the community: patients can always reach someone on the team by phone.
Barriers	▶ Huge challenge with staffing. Community has been unable to hire additional midwife for long periods. ▶ Rural community with limited public transportation makes it very difficult for families to travel to hospital in Chilliwack. ▶ No dedicated MOA for maternity ▶ Need funding for doulas to attend births
Things They Would Have Done Differently	▶ More admin support and training right from the start about how to bill for midwifery.
Contact	midwives@seabirdisland.ca

PART 4
Resources to support team-based care

- **Enhancing Interprofessional Collaboration in Maternity Care: Pathway to Positive Change Community Toolkit (2018) –** https://sharedcarebc.ca/sites/default/files/IPC%20Maternity%20Toolkit%20Sept%202018%20-%20Email%20and%20Web%20%28ID%20228182%29.pdf
- **Nurse in Practice Program (MoH Funded) –** https://www2.gov.bc.ca/gov/content/health/nurse-in-practice-program
- **Doctors of BC Practice Support Program (must have FP involvement in team-based care model) –** https://www.doctorsofbc.ca/managing-your-practice/quality-improvement/practice-support-program-psp
- **Doctors of BC Business Pathways Toolkit (Legal to Operational support for team-based care included) –** https://www.doctorsofbc.ca/business-planning-toolkit
- **Quality Team Coaching for Rural BC –** https://rccbc.ca/initiatives/qtc4rbc/
- **TBC @ UBC Network –** https://health.ubc.ca/tbc
  UBC Health Contributing to a vision of team-based care for the future of primary care in BC
- **Rural Obstetrical & Maternity Sustainability Program (ROAM-SP) –** https://rccbc.ca/initiatives/roam/
  RCCbc The Rural Obstetrical and Maternity Sustainability Program (ROAM–SP) funds maternity teams in rural British Columbia to strengthen their peer, facility and regional networks and enhance rural maternity care services
- **Team-Based Care BC –** https://teambasedcarebc.ca/
  Many resources for team-based care in BC, an initiative by the Ministry of Health
- **HQBC Teamwork & Communication in Action Series –** https://healthqualitybc.ca/sharpen-your-skills/teamwork-and-communication-actions-series/
  In this interactive series, your interdisciplinary team will work through five modules to master the skills needed for effective teamwork and communication
- **UBC CPD Communication Course for Health Care Professionals: Navigating Challenging Conversations Across the System –** https://ubccpd.ca/learn/learning-activities/course?eventtemplate=297-communication-course-for-health-care-professionals
  Beyond general communication skills, this workshop will teach you new approaches to speaking with patients and colleagues, while learning specifically how to navigate difficult conversations
- **Rural Continuing Medical Education Community Program (RCME) –** https://rccbc.ca/initiatives/rcme-programs/communityrcme/
  Makes funds available to groups of physicians living and delivering care in Rural Subsidiary Agreement (RSA) communities, to address their collective learning needs
- **UBC Innovation Support Unit, Primary and Community Care (PACC) Mapping, Maternity Bundle –** https://isu.ubc.ca/our-work/mapping-tools-resources/pacc-mapping/
  PACC Mapping is an engagement and planning approach that helps communities collectively explore how they could address local primary care needs such as attachment and other specific service gaps

Team Based Care Working Group from the Perinatal Community of Practice

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Provincial Primary Care Medical Lead
Perinatal Services BC

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Provincial Perinatal Community of Practice, Co-Chair

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Board Member, Midwives Association of BC

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