Creating a Maternity Community of Practice in BC
Inaugural Engagement Event - November 29, 2021
REPORT

Report Content

This event report includes the following content (*page numbers in brackets*):

OVERVIEW

On Monday November 29, 2021, the inaugural engagement meeting to create a Shared Care Maternity Community of Practice, took place, virtually, via Zoom, from 8:30am to 1:30pm.

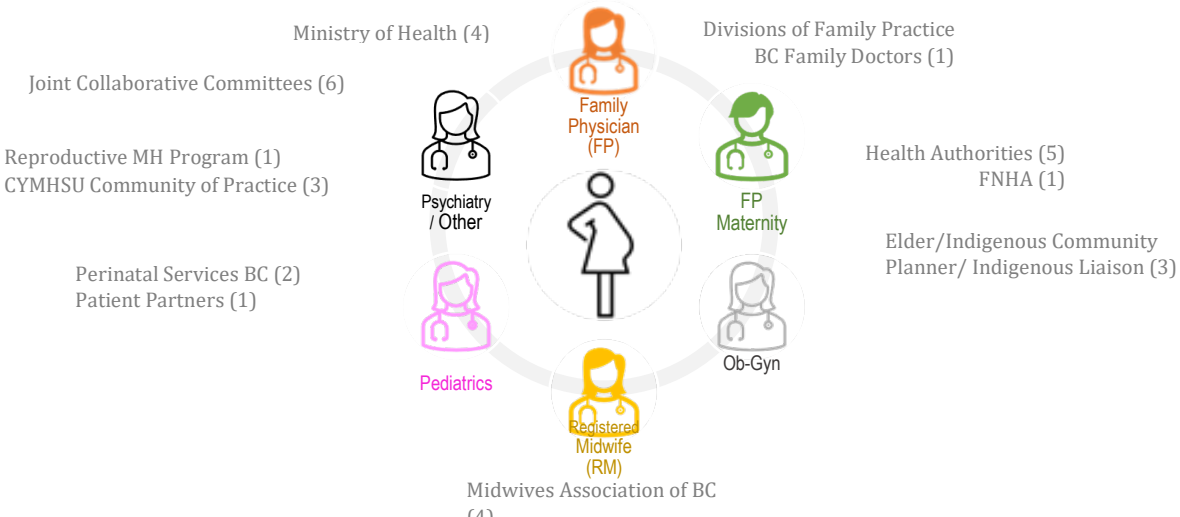
Objectives

Bringing together physicians, midwives, and other healthcare partners, the purpose of this first of its kind event was to:

- Build relationships between physicians, midwives & healthcare partners
- Describe the Maternity Community of Practice shared purpose and vision
- Validate maternity care priorities
- Lay the foundation for an integrated system of care
- Establish-concrete actions for a collective way forward

Participation

An intentionally small, representative group of 35 key health care providers & partners, including family physicians, midwives (RM), obstetrician-gynecologists (ob-gyn), reproductive psychiatry, Ministry of Health leaders, Indigenous leaders (Elder Dr Roberta Price, Nicole Cardinal, Jessica St. Jean), Health Authority perinatal leadership, and patient partners, actively participated in the highly interactive engagement session. The diverse group of community leaders and influential champions attended from a variety of regions across the province.



FP/FP Maternity: 10 | Ob-Gyn: 4 | Pediatrics 1 |Psychiatry: 2 | RM: 3

Design, Facilitation, & Support

The inaugural event, designed and organized by **Jennifer Scrubb**, MSc (consultant, report author), was supported by eight doctors of BC staff, and facilitated by Brian Evoy facilitator (consultant).

Highlights of the Day

1. Land Acknowledgement

Dr Shelley Ross, family physician (Burnaby), and Co-chair of the Maternity Community of Practice (CoP) Core Team, welcomed participants, acknowledged the privilege of using and sharing the land from which the virtual meeting was being broadcast, and introduced her Maternity CoP Co-Chair **Dr Julie Wood** (Ob-Gyn Burnaby), along with remaining **CoP Core Team members**: Dr **Cathy Clelland** (Tri-cities), **Lehe Spiegelman** (Sechelt), **Jessica St. Jean** (Campbell River), and **Dr Brenda Wagner** (Sunshine Coast, formerly Richmond).

"We would like to begin by acknowledging that the land from which this virtual meeting is being broadcast is on the traditional territories of the Coast Salish peoples including the Musqueam, Squamish, and Tsleil-Waututh Nations whose historical relationship with the land continues today. Acknowledging that we are on the traditional territories of First Nations communities is an expression of cultural humility – that we are privileged to use and share this land – and involves recognizing our duty and desire to provide culturally safe care to First Nations, Inuit, and Métis people in BC." **Dr Shelley Ross**

"We thank the Shared Care Committee - a joint collaborative committee representing a partnership between Doctors of BC & the Ministry of Health - for supporting this new Maternity Community of Practice."

Dr Shelley Ross
Maternity Community of Practice Co-chair.

Participants expressed gratitude for joining the engagement event from:

- *Lhtako Dene Nation.*
- *Ancestral territories of the Lekwungen Peoples, the Esquimalt & Songhees First Nations (and acknowledge Metis Charter Nation of Victoria).*
- *Beautiful unceded ancestral territory of the Sepwepemc First Nations Peoples.*
- *Unceded, traditional lands of the Syilx Peoples.*
- *Unceded traditional territory of the K'omoks, Pentlatch and Iyiksan People.*
- *Traditional territory of the Coast Salish Tsawout Nation.*
- *Unceded & traditional shared territories of the Katzie, Semiahmoo, Kwantlen, Kwikwetlum, and Tsawwassen First Nations.*
- *Unceded territory of the Qualicum Nation.*

2. Welcome & Blessing

Elder Dr Roberta Price, Coast Salish Matriarch and Elder, gracefully and graciously offered a warm welcome and wholesome blessing - for participants' minds, hearts, bodies & spirits - to enable good, positive, and respectful thoughts and words - as well as blessings of peace, comfort, and safety for those experiencing grief & loss.

3. Opening Remarks

Mr. Ted Patterson, Assistant Deputy Minister (ADM), Primary Care Division, Ministry of Health, and General Practice Service Committee (GPSC) Co-Chair, shared the Ministry's vision for maternity care as well as plans that can be aligned with while working towards developing BC's Maternity Community of Practice. Specifically, Mr. Patterson:

- Introduced his role with the Ministry, spanning multiple divisions and portfolios, including a newer responsibility **to ensure the Maternity Services Strategy is implemented in collaboration with PHSA and other key partners** (including those attending the Maternity Community of Practice engagement event);
- Provided a high-level overview of the provincial vision for maternity care - with the **Maternity Services Strategy as the North Star**, setting the vision for the future - and noted that although it is a long road ahead, we're on the right path to transformational change;
- Emphasized the importance of **bringing care closer to home** and back to Indigenous families (including Métis and Inuit people), **team-based care**, and learning from and **sustaining care in rural and remote communities**; and
- Shared thoughts about the role of the Joint Collaborative Committees and the Maternity Community of Practice in maternity care, including identifying and addressing common issues, and providing an opportunity for **knowledge exchange**, **idea generation**, and **collaborative action planning to enable an integrated, seamless system, firmly anchored in a broader primary care strategy.**

4. Virtual Networking & Icebreaker

Prior to delving into deep discussion, event participants **connected** with one another, through smaller break out groups, by sharing their experiences of memorable births and words of advice, received or given, regarding maternity care.

5. The Child & Youth Mental Health & Substance Use Community of Practice Experience: *Learning from the Past to Shape the Future*

Dr Matthew Chow (Child & youth psychiatrist & Doctors of BC President), **Dr Robert Lehman** (family physician based in Gibsons), and **Dr Shirley Sze** (family physician based in Kamloops) shared their experiences around developing the highly regarded Child and Youth Mental Health and Substance Use (CYMHSU) Community of Practice (CoP), including defining a CoP, reviewing its history and organization, outlining high level achievements and impact, and imparting words of wisdom to inspire and inform an approach to developing a maternity Community of Practice.

SharedCare
Partners for Patients

How do we define a Community of Practice?

- A group of individuals normally working on their own, with common experience and knowledge, who self select to be members of a community due to passion for a particular area of practice.

Unique Attributes of a CoP:

- Core of participants, with passion for the topic, providing intellectual and social leadership
- Informality & self-perpetuation
- Developing capacity to build and exchange knowledge
- Free flow of ideas and concerns

CYMHSU CoP History:

- Evolved from the CYMHSU Collaborative (2014 – 2017) involving 64 Local Action Teams and 2600 individuals with a desire to continue innovative, creative, and community/grass roots driven work and valuable connections.

Benefits of the CYMHSU CoP:

- **Stability -** *through regular biannual meetings, regular working group meetings, constant funding and staff support for the work.*
- **Safety -** *collective action, appropriate framework, measurement by output.*
- **Sensing -** *input of members held and valued - they are* ***seen & heard*** *from during meetings, through a variety of methods.*

CoP Development Process:

- Key development activities included developing a steering committee, holding annual gatherings, identification & prioritization of burning issues on the ground, establishment of working groups aligned with priorities, & development of a strategic plan.

Early Successes

- Internal webinars, in collaboration with UBC CPD, enabled the CYMHSU CoP to reach many individuals it otherwise would not have reached.

High Level Successes

- Funding for non-pharmacologic therapy (counselling, psychology).
- Access to services based on needs and function rather than arbitrary criteria.
- More support for substance use: Destigmatizing, decriminalizing, saf(er) supply.
- Taking social determinants of health seriously - housing, poverty reduction, childcare, anti-racism.

The Community of Practice is like a cement mixer - churning issues & challenges and collaborating to generate ideas & work on solutions - with hope & optimism coming out of the mixer.

6. Maternity Services Strategy: *Advancing Maternity Care in BC. A Provincial Approach.*

Dr Ellen Giesbrecht (Ob-Gyn; Interim Medical Director, Perinatal Services BC; Senior Medical Director, Quality, Safety & CST Implementation, BCWH) on behalf of D. Kendra McPherson (VP of Clinical Improvement & Transformation, PHSA) and Perinatal Services BC, presented an overview of the Maternity Services Strategy (MSS). Highlights are summarized below.

Why develop a vision and strategy for Maternity Services in BC now?

- The MSS vision was initiated in November 2019 in response to the closure of multiple sites in the province (including a crisis in Chilliwack and other communities) resulting in a need for a comprehensive analysis of the situation.

How was the strategy developed?

- Development of the MSS involved: engagement of provincial partners; qualitative approaches (including hearing experiences of patients, providers, & teams); and quantitative approaches (review of evidence, data, analysis).

What did we hear?

Continuing gaps and challenges including (but not limited to):

- Change in demographics (e.g. increase in average age at first pregnancy & increasing pre-pregnancy weight and concomitant challenges of gestational diabetes and hypertension)
- Lack of access to standardized modern prenatal education
- Lack of postpartum support
- Lack of timely access to support for mental health issues
- Need for clinical backup to support patient care
- Declining supply of FPs providing maternity care & limited supply of registered midwives
- Limited access to deliver in home communities
- Lack of structural supports for team based maternity care (e.g. training, remuneration, & communication systems)
- Lack of culturally safe, trauma-informed maternity care

MSS Vision: Stronger teams, stronger communities: together for better births.

- With best outcomes for parents & babies

"MSS success is embedded in a strong primary care delivery model."
"Interprofessional Team Based Care is a model for success."
"The Maternity CoP is an excellent way we can start to move the dial on some of the MSS initiatives – this requires the work of all of us."

Linking to the Primary Care Network (PCN)

- The Ministry is prioritizing maternity services within the PCNs.
- Ted Patterson and Shana Ooms are involved in discussions regarding where the MSS fits into the PCNs to: ensure communities are prioritizing maternity; explore how these services are being organized; and identify what resources are needed by the Ministry to bring these services to bear.

Seven MSS Guiding Principles - intended to:

- Reflect a patient-centred approach
- Acknowledge pregnancy and childbirth as normal life events
- Aim to improve health outcomes for women and infants
- Incorporate cultural safety and trauma-informed practice
- Work together in partnership with women to ensure seamless care
- Build on existing projects and successes
- Ensure fiscal responsibility and sustainability

Five recommendations and 11 initiatives (40 projects) guide the MSS

Recommendations	Initiatives
1. Partner with communities to embed cultural safety as part of maternity and newborn services	• Integrate cultural safety into prenatal education • Gather & learn from experiences of Indigenous people, families, and communities in co-designing maternal and newborn services.
2. Enhance supports for rural and remote maternal and newborn care	• Strengthen access to high quality maternity & newborn care as close to home as possible.
3. Attract and retain an interdisciplinary network of skilled maternity and newborn care providers	• Integrate new evidence into provider practices • Develop an educational plan that supports providers to maintain a range of maternal & newborn care competencies. • Move towards sustainable inter-professional team-based models. • Provincial approach to workforce planning.
4. Adopt a quality framework to inform priorities and track progress	• Leverage data to improve care • Inform system-level planning through available data • Develop provincial quality standards to improve the quality of maternal and newborn care.
5. Strengthen system-wide planning and coordinator for maternal and newborn services	• System integration is supported through enhanced networks.

Six Short term stabilization projects underway to address immediate concerns

1. Rapidly review the rural/remote contracts to address issues of supplementation, hours of service and on call coverage
2. Investigate how to expedite privileging for maternity service providers
3. Support primary care network and maternity services planning for vulnerable communities to create and sustain team-based collaborative models

4. Complete an environmental scan of training options for neonatal stabilization
5. Investigate BC Neonatal Resuscitation Program (NR) standards and make provincial recommendations.
6. Enhance access to Fetal Health Surveillance (FHS): Launch virtual health pilot for instructor training, expedite next cohort of instructors.

Three-year roadmap of proposed projects by initiative – how are we going to get there?

- Year 1 of the MSS has begun (summer 2021)

In response to the MSS overview, the following opportunities were identified by participants:
Opportunity for: • Maternity CoP members to work on Refreshed Care Pathways project • Further exploration of high C section rates (BC has the highest rate in Canada) • Collaboration to work on recruitment of women, including Indigenous birthers, into Indigenous communities.

7. Maternity Services Strategy - Question & Answer Session

1. **Where are the 6 rapid response projects focussed today?**
    - One is complete
    - Compensation models = ongoing
    - Working together with PCNs = ongoing
    - Education: completed initial assessment, now in costing phase

2. **Will evaluation of contracts take place across provider groups and what would that look like re: sorting out the differences?**
    - A comprehensive approach is being taken, involving all providers at all sites across the province, with each contract (midwifery and primary care).
    - NPs, midwives, and FPs will be engaged in this iterative, learning process to review all contracts and to identify opportunities.

3. **What are the names of the communities for rapid response?**
    - All contracts in small communities (rural and remote) will be reviewed.
    - '1A' (old language) communities = Port Hardy, Port McNeill, Haida Gwaii, Hazelton, Invermere.

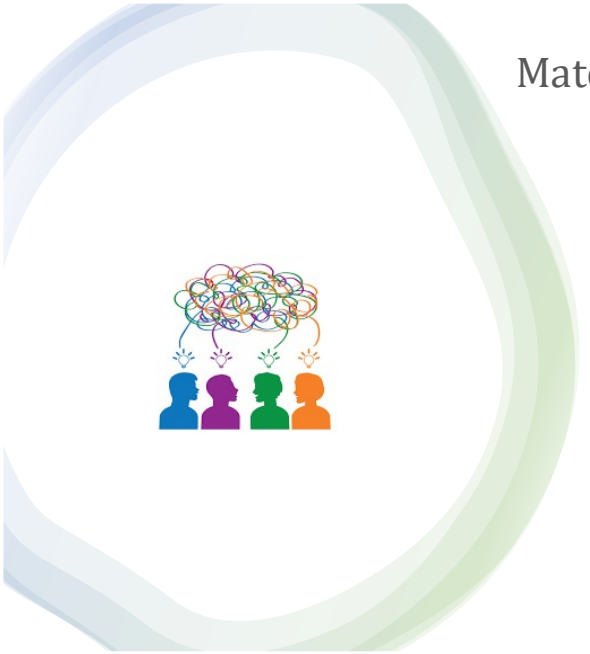
4. **Will there be further work re: provincial credentialling (including equity and diversity)?**
    - This issue may need to be taken to the provincial credentialling table (GPOC?)

5. **Where do you feel Indigenous midwifery fits in the MSS?**
    - This fits with human resources (e.g. do we have enough training spots, enough Indigenous midwives applying for spots, and of those serving in Indigenous communities, how many are Indigenous?).
    - This identified need across the province requires discussion at the level of the educational institution.

6. **Has the Physician Services Commission (PSC) addressed the compensation rate differential to raise the midwifery rate to enable equitable participation of midwives in maternity projects** (e.g. non-clinical, collaborative work)?
    - **Action: Ted Patterson to follow up (at provincial table) for an answer.**

8. Maternity CoP: Purpose, Vision, & Priorities

Prior to deeper discussions to shape the CoP, Co-chairs Dr Julie Wood and Dr Shelley Ross introduced the CoP proposed **shared purpose, shared vision**, for group consultation and feedback.



What are we trying to do?

- We're aiming to build our Community of Practice, transitioning from & leveraging the Maternity Spread Network, aligning with the Maternity Services Strategy & expanding to include all maternity care providers & broader system partners (at the community, regional, and provincial level) in BC.

Why? Shared Purpose

- The Community of Practice provides an opportunity to support not only the pregnancy journey, but overall health & well-being of young women, aging women, and their babies, as well as address gaps in the system by equipping physicians, midwives, & their healthcare partners with resources to foster relationships, share knowledge & together optimize patient care.
- With more resources (through the Shared Care Committee), & more players, we're striving to build synergy, & keep the momentum going.
- The Community of Practice is about action - harnessing collective energy to achieve something mutually beneficial.

Based on group feedback, suggested revisions to the shared vision & CoP name are summarized below:

Revision to CoP Name - based on collective input to better reflect the dyad/family (vs. solely the mother):

- **Original:** Maternity Community of Practice || **Revised:** Perinatal Community of Practice

Revision to Shared Vision - based on collective input for inclusivity and specificity re: Indigenous cultural safety & humility.

- **Original:** Maternity care is person-centred, timely & accessible, culturally safe & seamlessly integrated as a core service of the PMH-PCN.
- **Revised:** Perinatal care is person & family centred, timely and accessible, culturally safe (*Indigenous cultural safety & humility*) and seamlessly integrated as a core service of the PMH-P CN.

Community of Practice Priorities – *Did we get them right? What's missing?*

Dr Ross introduced **three preliminary maternity care priorities**, based on a survey conducted earlier this year - engaging maternity care providers and health care partners throughout the province - and through subsequent discussions for group consultation and feedback.

Based on group feedback, suggested revisions to maternity care priorities, are outlined below:

Revised Priorities – based on collective feedback to avoid stigmatizing language & embrace empowering language

1. **Original:** Mental Health & Maternity Care || **Revised:** Mental Health, Substance Use & Perinatal Care
2. **Original:** Prenatal & Postnatal Care Access, Continuity, Transitions --- No suggested revisions
3. **Original:** Maternity Care for Vulnerable Patients || **Revised:** Perinatal care for patients experiencing vulnerability

- **Marginalized || Revised:** People who are marginalized
- **Indigenous families || Revised** (including Metis & Inuit families)
- **New immigrants** *[To be Confirmed]*
- **Low income** *[To be Confirmed]*
- **Medically high-risk** *[To be Confirmed]*
- **NEW subcategory:** People without geographic access to care (e.g. rural and remote communities)

NEW Priority: Supporting Providers

NEW Overarching Theme: Protecting Relationships - of people to their: community, baby, culture, family, care provider; & between care providers.

The following opportunities emerged from the group in response to the preliminary maternity care priorities:

Opportunity for:

- Collaborative creation of a parallel set of priorities specific to Indigenous families – emphasizing specific components to mirror the priorities described above.
- Further discussion & collaborative work to ensure priorities are inclusive.
- Further discussion & collaborative work to ensure the CoP aligns with & contributes to the Maternity Services Strategy, leveraging the collective expertise of CoP members - How do the priorities fit with the MSS?

Note: All issues under priority #3 apply to Indigenous families (including Métis & Inuit families)

9. Deeper Dialogue on Maternity Care Priorities

Using a quasi-World Café format in smaller breakout rooms, event participants engaged in deeper dialogue regarding perinatal priorities to inform development of the Community of Practice and its related strategic plan. As part of the dialogue, they delved into the following:

- *What are the greatest needs? Where do we focus our efforts?*
- *What's most important to consider when we organize around each priority?*
- *What's working well? What can we build upon/do more of/learn from?*
- *How do we know we're making a difference? How do we know a change is an improvement?*

A high-level summary of the breakout room dialogues on maternity care priorities is below:

Priority #1: Mental Health, Substance Use and ~~Maternity~~ Perinatal Care

- Importance of peer support and helping patients to help themselves.
- Early engagement, information, education, resources, & support - continued throughout each stage of the journey.
- Leveraging virtual care to support isolated and rural communities, connect with peers and experts.
- Lack of infrastructure and basic internet access in the northern and rural/isolated communities.
- Recognizing historical and ancestral/generational trauma and healing in the journey of the patient.
- Systemic misplaced perceptions of parents experiencing vulnerability not being equipped to continue care.
- Capturing any communities without health services in CoP strategies & plans.

What's Working Well? *Mental Health, Substance Use and Perinatal Care*

When discussing models of care that we can learn from, do more of and/or build upon, to inform the CoP, **team-based care models** were the predominant theme. **Examples include:**

- Apple Tree maternity clinic (Kootenay-Boundary): https://www.appletreematernity.com/
- South Community Birth Program (Vancouver): https://www.scbp.ca/
- Seabird Island clinic -with Midwife (Agassiz): https://www.seabirdisland.ca/maternal-child-health/
- Kwakwaka'wakw maternal child program, including maternity care and Doula care
    - https://www.fnha.ca/about/news-and-events/news/midwife-connects-life-givers-to-traditional-birthing
- Doulas for Aboriginal Families Grant Program (DAFGP, run by BCAAFC with funding from MOH/FNHA): https://bcaafc.com/dafgp/
- Rural Obstetrical and Maternity Sustainability Program (ROAM-SP) - enables the delivery of sustainable rural maternity services by identifying, developing, and supporting peer, facility, and regional networks.

Priority #2: Prenatal & Postnatal Care: Access, Continuity, & Transitions

Where do we focus our efforts? Two themes emanated from the discussion:

- **Improving Access** to:
    - Diagnostics (ultrasound) especially in rural communities to reduce lengthy wait times & improve the patient experience.
    - Technology for Indigenous communities.
    - Lactation/breastfeeding support.
    - A primary care provider/PMH for unattached patients.

- **Better Transitions** of care:
    - In rural communities
    - Bringing care to the communities, where there are family & other supports, reducing the need for patients to leave their home communities to give birth.
    - Returning to communities with tools for successful parenting.
    - Optimizing team-based care.
    - Aiming for seamless transitions in care b/w providers, communities & acute/community across the care continuum.

Priority #3: Patients Experiencing Vulnerability

Where do we focus our efforts? Ideas are organized by system, provider, & patient level**:**

System level

- Ensuring the system places **patients at the centre** of all care
- Clearly identifying system vulnerabilities
- Finding ways to **design the system around the care model**
- Addressing **racism & discrimination**
- Improving **cultural support** (e.g. cultural liaison)
- Improving **access to the system** - via trust building, transportation, etc. - bringing the system to the patients/families.

Provider level

- More **awareness & training re: those experiencing vulnerability**
    - generational trauma
    - closeness and connection
    - trauma & life experiences
- Better understanding and **knowledge of & support for Indigenous community**
- Focus on the care the family would like to receive (vs the service) including family – family connections
- Define scope, compensation, roles

Patient/Family level

- **Caring, connected relationships**
    - birthing person + infant
    - attachment & connection with community
    - Individuals with mental health concerns at risk of self harm or harming their child
- Identifying moms who use substances during pregnancy and creating a model of care to support them
- **Bonding & attachment** in the early years

What's Working Well? *Patients Experiencing Vulnerability*

When discussing services and initiatives for patients experiencing vulnerability that we can learn from, do more of and/or build upon, the following examples emerged**:**

- "Connecting pregnancy" (practice-based virtual) to help women experiencing mental health issues: http://birthdocs.ca/connecting/
- Sechelt
  - having appropriate services for patients who use substances
  - having one-stop shop services & resources for pregnant women in the same place
  - connecting well through the PCN
- Urban centers - in house resources model
  - Leverage & adapt for other communities
- Referring services through the PCN
- ACES education
- Expanding Indigenous spaces at all levels
- Expanding Indigenous knowledge, Act on Calls to Action
- HA taking on roles to help lifting people up to help assist in caring for patients and their families
- More Elders to assist

10. Advancing Maternity Care Priorities through the Maternity Community of Practice

Attendees were asked to reflect on their deep dialogue regarding maternity care priorities and to suggest: **How can the CoP help advance perinatal priorities and goals?**

In response, participants suggested that a **perinatal CoP can help to:**

*- **Define the model of care** - what is the care, what is the end goal, what are wrap around supports? Opportunity to inform provincial policy.*

*- **Convene & unify** multiple and varied provider voices, providing a conduit/mechanism to guide policy.*

*- **Drive change**, through meaningful conversations (re: people we serve) and provide services in an integrated way.*

*- **Foster growth of a culturally safe system** – through more touchpoints along the patient journey.*

*- **Expand & interconnect** scope between all communities (subway system connecting all communities).*

11. Closing Remarks & Evaluation

Dr Ross expressed her appreciation to all participants and noted her anticipation of working together to advance the goals of the Community of Practice. Subsequently she introduced Shared Care Committee Co-chairs, **Shana Ooms** (Executive Director, Primary Care, Ministry of Health) and **Dr Jiwei Li** (Family Physician) to provide closing remarks.

Ms. Shana Ooms remarked on the passion, dedication, and commitment of the individuals assembled during the inaugural event, and during her reflection on the day, eloquently highlighted:

- The importance of bringing the **Indigenous lens** to this work.
- **The vision for a successful system of maternity care** – including care that is:
  - Provided **closer to home.**
  - **Equitably accessed** by all people who need care with a particular focus on those that have greater barriers (e.g. rural and remote, and Indigenous people, including Métis and Inuit people).
  - **Coordinated, integrated**, **person and family centred**, and **team focussed** (most importantly).
  - **Anchored in a primary care strategy**.

Ms. Ooms also commented on seizing the opportunity to:

- Reflect on our collective **commitment to reconciliation**.
- **Leverage shared scopes of practice**, to enable collaborative practicing in new ways and to introduce and emphasize other providers and their roles in the maternity system (e.g. Indigenous midwives and Indigenous Doulas).
- **Build confidence and competence** through training and supports for providers.

Significant **challenges** re: maternity care were acknowledged, including **human resources** and **compensation,** which will require a longer-term focus, although recognizing some issues can be addressed in the short term.

Further reflections included:

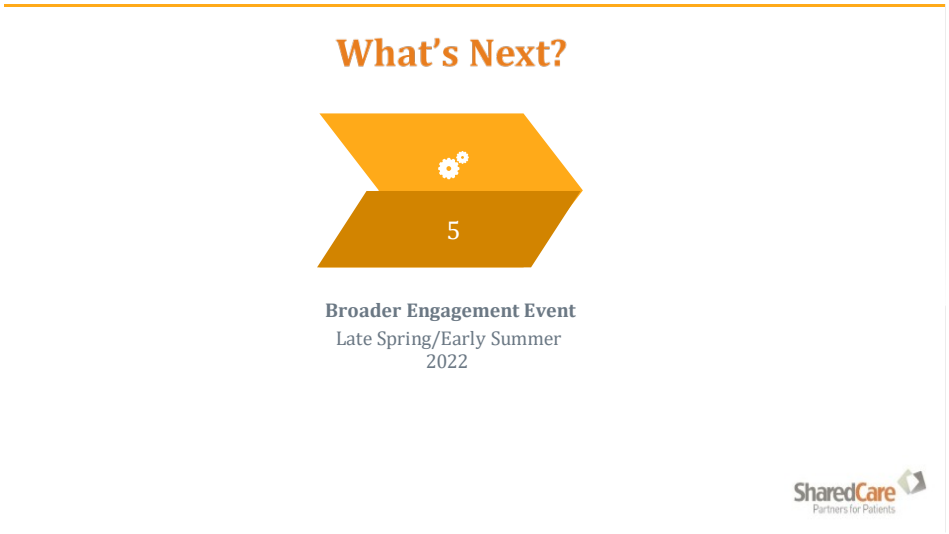
- Experience and learning from the Child and Youth Mental Health and Substance Use Community of Practice - in which members can be seen, heard, held, and valued - serving as a blueprint for action re: maternity services in the province.
- The **reciprocal relationship between the MSS and the maternity CoP**, with synergy and possibilities created through fortuitous timing.

Think outside the box! **Dr Jiwei Li - SCC Co-chair**

> ***Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.***
> ***Margaret Mead***

12. Next Steps

- Before closing the event, Dr Wood outlined next steps in the CoP creation process, while emphasizing the importance of maintaining flexibility with this work and committing to keeping all informed as the work progresses:
    - Core Team Debrief: December 2021
    - Engagement Event Report Distribution: January 2022
    - Working Group Discussions: Feb/Mar 2022 (preliminary, TBD)
    - Strategic Plan, Action Plan, Evaluation Framework Development: Feb-June 2022
    - Broader Engagement Event: Late Spring/Early Summer



13. Evaluation Report

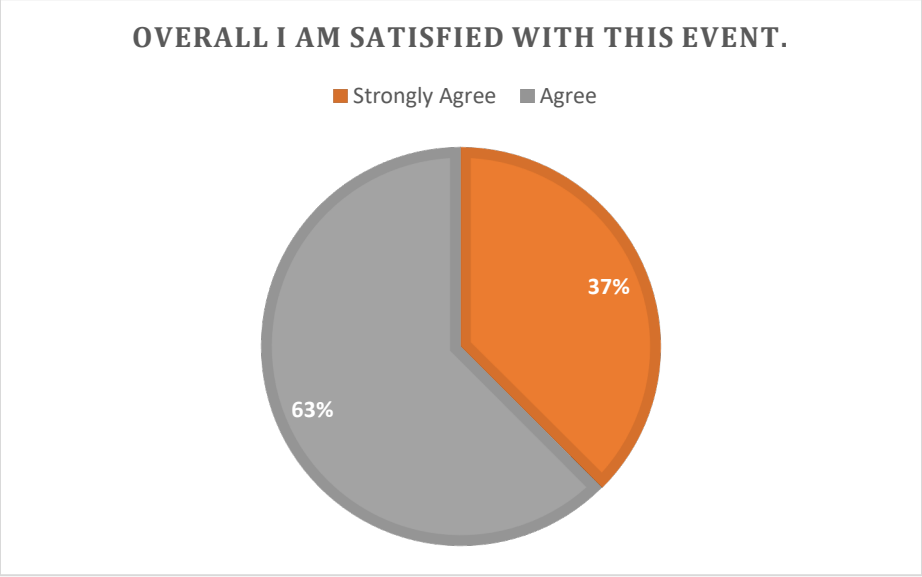
All event participants were encouraged to complete a brief online evaluation survey before signing off, to: determine their overall satisfaction with the event & whether event objectives were met; identify participant interest in engaging in CoP working groups, MSS projects, &/or a Perinatal Services BC project; and identify opportunities for improvement.

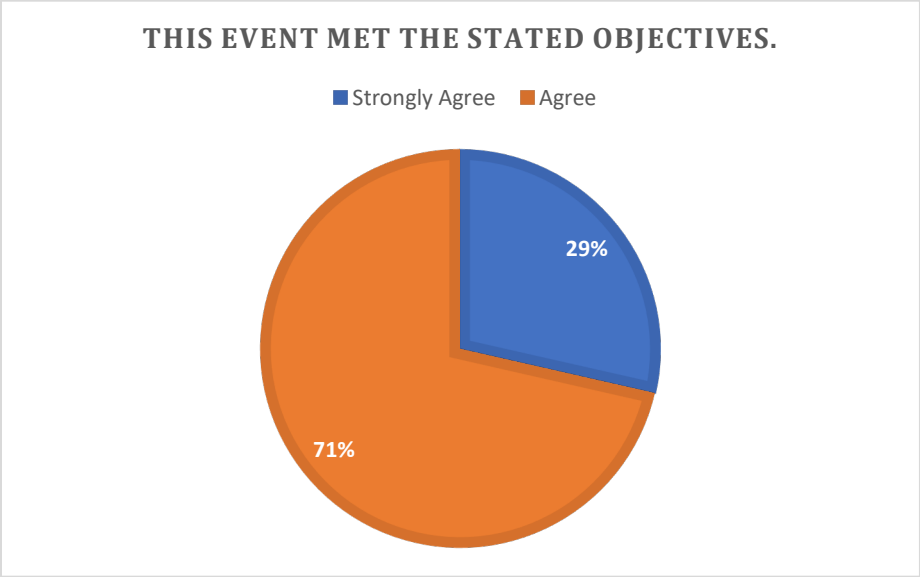
Eight participants completed the survey (23% response rate). Unsolicited feedback from the Zoom chat box is also included at the end of the evaluation summary.

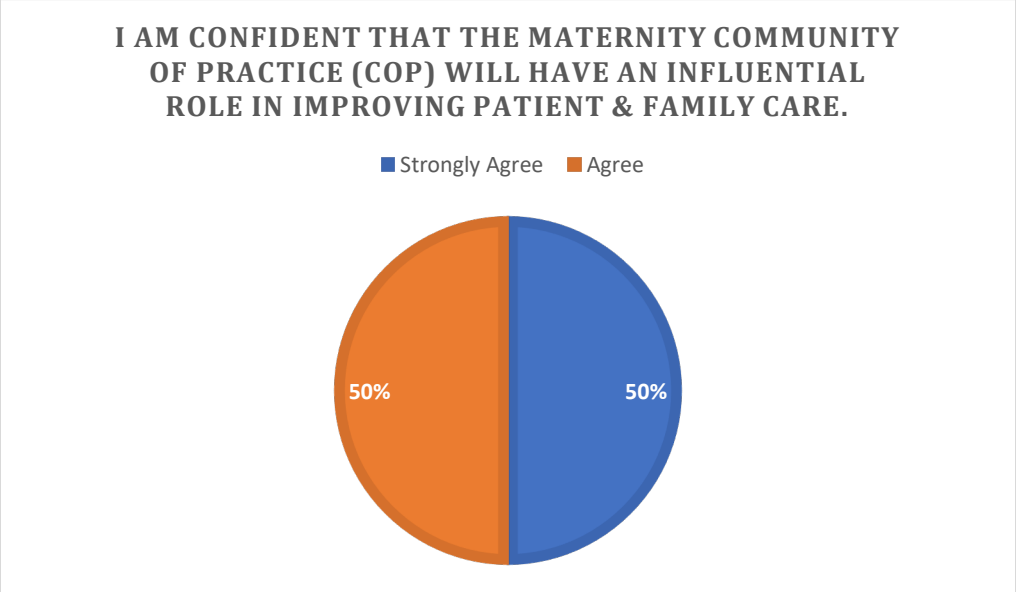
Summary of Survey Results

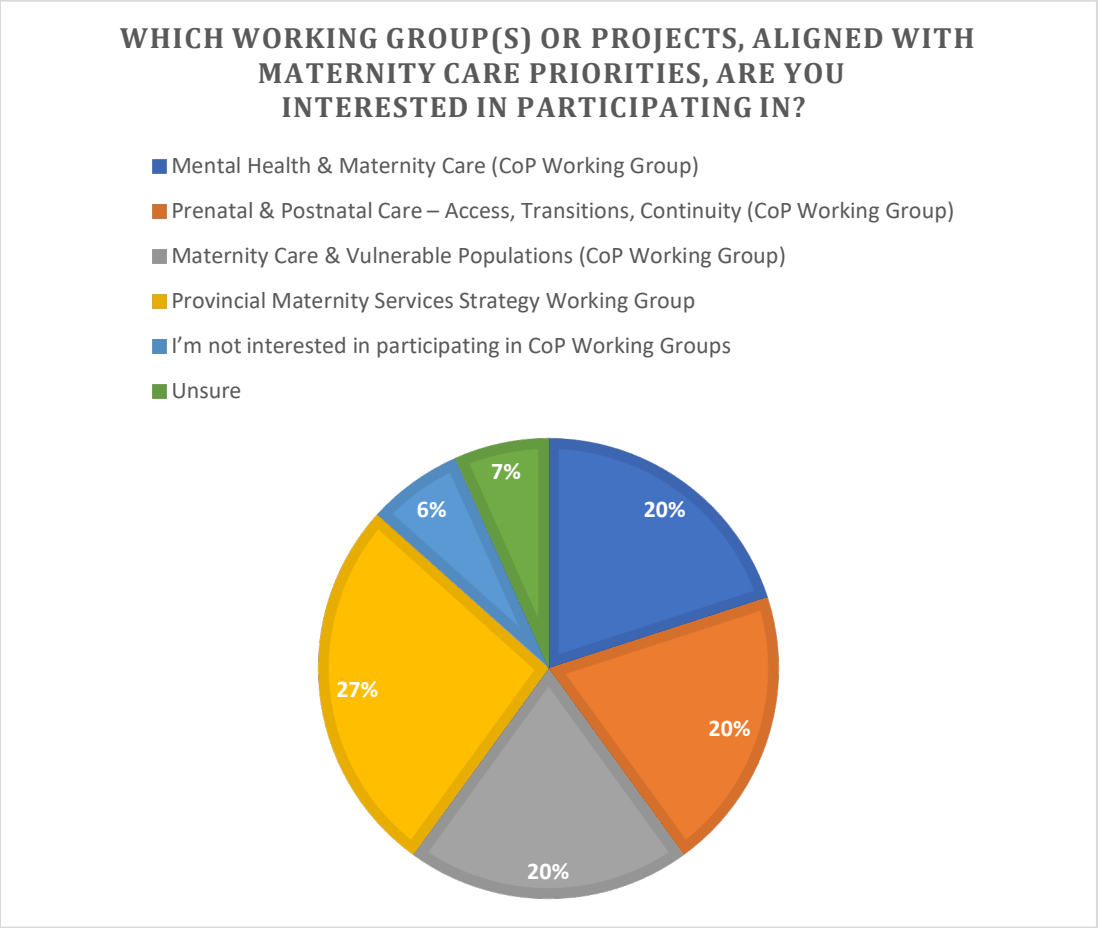
What was the most valuable or interesting aspect of today's event?

- ***Broad group of participants*** *brought so* ***many viewpoints*** *to the conversation.*
- *Hearing the* ***different perspectives*** *from care providers, Ministry & Health Authority leads, all dedicated to improving the care provided to pregnant and postpartum women in BC.*
- *Hearing from the* ***varied viewpoints*** *and beginning to sift through future priorities.*
- ***Listening to women & families***
- ***Group dialogues***
- ***Surfacing the challenges*** *at the grassroots level*
- *Hearing the* ***largescale vision*** *for an innovative project with real potential to support perinatal care sustainability & improve the relationships within the perinatal care systems.*
- *Opportunity to bring forward the vital nature of the care received on all aspects of the journey*
- ***Grounding in the MSS***
- ***Inspiration & value of the CYMHSU CoP***
- *Importance of* ***Indigenous knowledge*** *&* ***birth at home***



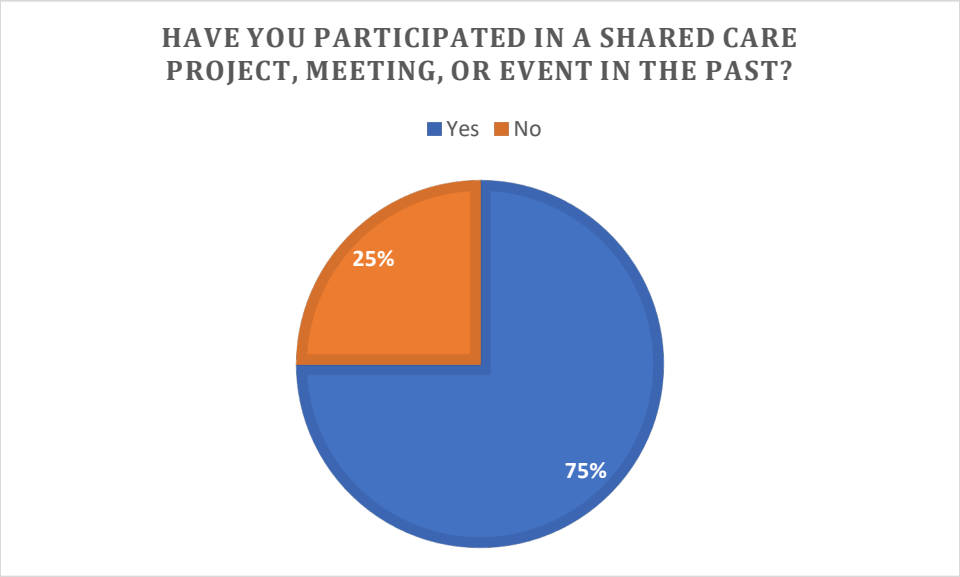

THIS EVENT MET THE STATED OBJECTIVES.
Strongly Agree
Agree
29%
71%


I AM CONFIDENT THAT THE MATERNITY COMMUNITY OF PRACTICE (COP) WILL HAVE AN INFLUENTIAL ROLE IN IMPROVING PATIENT & FAMILY CARE.
Strongly Agree
Agree
50%
50%



As the Maternity CoP develops, whom else should we engage (in working groups or other CoP activities)?
Diagnostic imaging, Public Health, NGO support services for mat/child, Doulas
Midwives**, **PCN**, **Mental Health Practitioners**, **Cross Ministries** to help integrate the work **Health Authority** leadership, **Public Health**, **Indigenous voices, Patient voices
***Public Health**, **More midwives** (with equitable funding)* ***Nursing** (hospital & community), **Doulas**, More **RCCbc** representatives*
https://www.fnha.ca/what-we-do/chief-medical-office/sacred-and-strong ***Dr Shannon Waters**, **Public Health**, **Indigenous Midwifery**, **Psychiatrist***
*MY Team at **FNHA**, **UBC** re: education on Cultural Safety, **Indigenous Midwifery**, **Doulas***
***Peds**, **Psychiatry**, **Health Authority** reps, Other **Ministries** (e.g. MCFD, MMHA, MSocDev & Pov Reduction)*
Mothers & their support people

What could have improved your event experience?
***Nothing**, this was excellent*
***Good balance** between information sharing and gathering essential input - I felt it was well balanced*
***More documentation for pre-reading** to ensure we were coming in with the same background information (particularly the maternity services strategy)*
n/a it was great
***It was well done**, thanks*
***It was a good experience** and I applaud the efforts of the organizers in making it so!*
*The meeting **could have been briefer**.*



Attendee Comments from the Zoom Chat

"Thank you for including me, this was a most helpful dialogue, have a lot to think about & reflect on."

"Thank you! Excellent use of time."

"I also wanted to thank the staff who have been supporting this agenda behind the scenes - you have created a wonderful day!"

"Happy to be part of the working groups in this inspirational work."

"Thank you to the leadership today, Dr Ross, Dr Giesbrecht, and Elder Dr Roberta. We all know the importance of birth, families, and this important work!"

"I very much look forward to ongoing consultation, collaboration, & partnership as the MSS moves forward - thank you."

"Many Kind Thanks [Shelley, Julie & Jennifer] for a warm welcome for this event…a great time of sharing, O Siem!"

SharedCare
Partners for Patients

APPENDIX

ATTENDEES

1. Jill Boulton - Interior Health; Neonatologist; Medical Director Perinatal & Neonatal
2. Bernice Budz - Executive Director, Midwives Association of BC
3. Karen Buhler - Family Physician; Vancouver Division of Family Practice
4. Nicole Cardinal - Indigenous Community Planner, VCH; UBC School of Community & Regional Planning
5. Matthew Chow - CYMHSU CoP Co-Chair; Child & Youth Psychiatrist President, Doctors of BC
6. Cathy Clelland - Family Physician; Maternity CoP Core Team
7. Jen Duff - VCH; Regional Director, Maternal Child Health Program
8. Robert Finch - Executive Director, Perinatal Service BC (PSBC)
9. Ellen Giesbrecht - Interim Medical Director, PSBC; OB-GYN; Senior Medical Director, Quality, Safety & CST Implementation, BCW
10. Renee Fernandes - Executive Director, BC Family Doctors; Family Physician
11. Zoe Hodgson - Clinical Lead, Midwives Association of BC
12. Jude Kornelson - RCCbc; Assoc. Prof., Dept of Family Practice
13. Robert Lehman - Family Physician; CYMHSU CoP Co-Chair
14. Anthon Meyer - GPSC Co-Chair; Shared Care Committee (SCC) Member; Family Physician
15. Loraine Jenkins - Fraser Health; Executive Director, Maternal Infant Child Youth Program
16. Elisabet Joa - OB-GYN (St Paul's Hospital)
17. Jiwei Li – SCC Co-Chair; Family Physician
18. Unjali Malhotra – FNHA; MHO, Women's Health
19. Shana Ooms – SCC Co-Chair; Ministry of Health (MOH), Executive Director, Primary Care
20. Barbara O'Meara - Patient Partner, Patient Voices Network
21. Erin O'Sullivan - Island Health; Regional Perinatal Program Development & Evaluation Lead
22. Charissa Patricelli - Addictions Specialist, Director Perinatal Addictions
23. Ted Patterson - MOH; ADM, Primary Care; Co-Chair GPSC
24. Elder Dr Roberta Price – Elder, Coast Salish Matriarch
25. Erin Price - MOH; Research Manager, Women's and Maternal Health
26. Shelley Ross - Maternity CoP Core Team Co-Chair; Family Physician
27. Deirdre Ryan - BCCWH; Department Head, Reproductive Psychiatry
28. Vanessa Salmons - Northern Health; Executive Lead, Perinatal Program
29. Sara Sandwith - RCCbc; Family Physician
30. Lehe Spiegelman - Maternity CoP Core Team; President MABC; Registered Midwife (RM)
31. Jessica St Jean - Maternity CoP Core Team; Indigenous Advisor MABC; RM
32. Shirley Sze - CYMHSU Co-Chair; Family Physician
33. Brenda Wagner - Maternity CoP Core Team; OB-GYN
34. Glenys Webster – MOH; Director of Women's, Maternal and Early Childhood Health
35. Julie Wood - Maternity CoP Core Team Co-Chair; OB-GYN

We respectfully acknowledge two invitees who were unable to attend the event due to unforeseen circumstances:

- *Kendra McPherson PHSA - VP Clinical Improvement & Transformation Lead/Maternity Services Strategy Lead*
- *Dr Maureen O'Donnell PHSA - Executive vice president of Clinical Policy, Planning & Partnerships*

PRIORITY: Mental Health, SU & ~~Maternity~~ Perinatal Care	**PRIORITY: Prenatal & Postnatal Care:** **Access, Continuity, Transitions**	**PRIORITY: Patients experiencing vulnerability**
SUMMARY		

• Importance of peer support and helping patients to help themselves
• Early engagement, information, education, resources, & support - continued throughout each stage
• Leveraging virtual care to support isolated and rural communities, connect with peers and experts
• Lack of infrastructure and basic internet access in the northern and rural/isolated communities
• Recognizing historical and ancestral/generational trauma and healing in the journey of the patient
• Systemic misplaced perceptions of vulnerable parents not being equipped to continue care
• Capturing any communities without health services in CoP strategies & plans
	Focus efforts on:
	• <u>Improving Access</u> to:
	  ○ Diagnostics (ultrasound) especially in rural communities to reduce lengthy wait times & improve the patient experience
	  ○ Technology for Indigenous communities
	  ○ Lactation/breastfeeding support
	  ○ A primary care provider/PMH for unattached patients
	• <u>Better Transitions</u> of care:
	  ○ In rural communities
	  ○ Bringing care to the communities, where there is family & other supports, reduce the need for patients to leave their home communities to give birth.
		Internal Note: Include those who do not have geographic access to care (rural and remote) as a vulnerable population - lots of data links distance to services with adverse outcomes in maternity care.
		
		Internal Note: consider new theme: "protecting relationships:" relationships of people to their community, to their baby, to their culture, to their family, to their care provider, and between care providers with one another.

	○ Returning to communities with tools for successful parenting ○ Optimizing team-based care ○ Aiming for seamless transitions in care b/w providers, communities & acute/community across the care continuum	
WHAT ARE THE GREATEST NEEDS? WHERE SHOULD WE FOCUS EFFORTS?		
SYSTEM/MACRO LEVEL		
• Culture shift to **broader system view** & breaking down silos	• **Access** to diagnostics - ultrasound (long waitlists) especially in rural communities.	• Clearly identifying **system vulnerabilities**
• **New models of care** reflective of communities	• **Access** for unattached patients	• Finding ways to design/build the system - **focussing on the system** vs individual – around the care model
• **Equitable access to basic infrastructure**, internet & virtual care (esp. rural/remote/isolated)	• **Access** to technology in Indigenous communities	• Improving **Access** to the system - via trust building, transportation, etc. - bring the system to the patients/families.
• Addressing barriers re: blended and shared practices	• **Access** to lactation/breastfeeding support	• Ensuring the system places **patients at the centre** of all care

• Increasing education on cultural humility (a **culturally safe system** benefits everybody)	• **Transitions** in rural areas	• Addressing **racism & discrimination**
•	• **Transition** back to community with tools for successful parenting.	• Improving **cultural support** (e.g. cultural liaison)
•	• Bringing care to the communities where there is support and family support	
	• Addressing safety issues for Indigenous communities	
	• Harm reduction	
	• Opportunities to widen RM & Others' scope of practice to meet patient/family needs	
	• Increasing the number of providers to provide services/care	
PROVIDER LEVEL		
• **More boots on the ground** in urban communities; connect people to one another; inclusivity (vs standard approaches)	• Filling the gap/Missing voice: diagnostic service providers, the bigger system.	• **More awareness & training** re: those experiencing vulnerability o generational trauma o closeness and connection o trauma & life experiences

• **Provider wellness**/mental health		• Better understanding and knowledge of & support for Indigenous community
• **Screening for social determinants of health** & expansion of nurse-family partnerships to support post-partum	• Specialists sometimes have to provide extra care to pregnant patients who have not seen a doctor previously in a long time.	• **Focus on the care** the family would like to receive (vs the service) including family – family connections
	• Standard of reporting	• **Define scope, compensation, roles**
PATIENT-FAMILY/COMMUNITY LEVEL		
• More **focus on the patient** rather than the provider	• Including family in care – leverage the human side	• **Caring, connected relationships** o birthing person + infant o attachment & connection with community
• Peer support in lower resourced communities		• Individuals with MH concerns at risk of self-harm or harming their child
		• Identifying moms who use substances during pregnancy and creating a model of care to support them
		• Bonding & attachment in the early years
WHAT'S MOST IMPORTANT TO CONSIDER WHEN WE ORGANIZE AROUND EACH PRIORITY? HOW DO WE ADDRESS THE PRIORITIES?		
SYSTEM/MACRO LEVEL		
• Changes in one part of the system affect changes in all other parts of the system!		

• System has been built fundamentally in a way that minimizes the experience of women & children (the people who it is supposed to serve)		
• **Addressing the stigma** of MH struggles		
• **Cultural differences** in multi-cultural communities and patients from other countries who have a different view and experience of both the health care system & the government as a whole		
• **Leveraging the workforce** to better support post-partum		
• **Some communities do not have support services**; develop strategies to address these gaps including ability for birth at/closer to home.		
• Prevention (better than cure)		
PROVIDER LEVEL		
• How much linkage is there with **Public Health** nurses for post-partum support?	• **Affordable care** is needed	• **More education** for providers and those in the education system o Cultural humility o How to support the community
• Impact of MH diagnosis/capacity & treatment on vulnerable moms – can lead to worsening symptoms if not treated properly	• Indigenous midwives are needed	• Minimize scheduling appointments & expand drop-in/walk-in opportunities if needed
• Timelines of post-partum programs don't match progression for Indigenous communities (mark		

stages of life in different ways not just at certain ages).		
PATIENT-FAMILY/COMMUNITY LEVEL		
• **Journey mapping** and finding out **what's important to our patients**	• **Ultrasound is needed** at community level in rural areas	
• **Patients** have expressed they just **need to feel heard**		
• Shame prevents people from asking for help		
• The patient should determine whether public health is involved – how do we identify those who might need the involvement early and how do we target those?		