



Proceedings from the Invitational Rural Midwifery Symposium

Sheraton Wall Centre Hotel, Vancouver, BC
June 19-20, 2008

Hosted by the Centre for Rural Health Research and the
MABC Rural Midwifery Committee



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Executive Summary

The *Invitational Rural Midwifery Symposium* on June 19-20, 2008 in Vancouver, BC, hosted by the Centre for Rural Health Research and MABC Rural Midwifery Committee, was organized to provide rural midwives with the opportunity to identify and communicate the barriers to sustainable midwifery practice in rural communities. Presentations (see Appendix) and the participants' discussions highlighted challenges, which the Centre for Rural Health Research compiled and thematically organized. These proceedings provide a comprehensive list of rural midwives' practice challenges, solutions to these issues, and target decision makers who can enact change.

Professional barriers to rural midwifery practice include inadequate locum coverage, lack of organized peer support, and challenges to the introduction of midwifery in new communities. The Ministry of Health and Midwives' Association of British Columbia (MABC) should fund rural locums and travel for meetings, while regional decision making bodies need to enhance dialogue between key stakeholders to facilitate the introduction of midwives.

Health service delivery issues include local histories of unassisted homebirth and lay midwifery, the impending retirement of experienced midwives, and intermittent or limited local specialist coverage. Midwives should educate their local communities on safety issues surrounding birth without trained support, as well as provide informed choice documents for local birth in the absence of specialist (surgical) back-up where appropriate. The MABC and Ministry of Health should create alternative funding models for limited practice, as well as a locum pool of established midwives to support new midwives in rural communities.

Education and continuing education barriers consist of difficulty in accessing midwifery education for rural residents, lack of rural-specific education, limited incentives for new graduates to enter rural practice, and finding time and funding for continuing professional development (CPD). The UBC Midwifery Education Program should enhance courses, mentorship, and skills training to include a rural focus, while the Ministry of Advanced Education and Training should consider increasing funding for students and compensation for mentors. Individual Health Authorities and the Ministry of Health are encouraged to create CPD financial support for rural midwives.

Privileging barriers for rural midwives include hospitals not granting privileges and challenges in using "courtesy privileges" at referral hospitals. Before applying for privileges, midwives are encouraged to become familiar with the rules and regulations of their regional process and to consult with neighbouring communities and care providers who have successfully integrated midwifery. Local and regional medical advisory committees can assist in developing a protocol for "courtesy privileges."

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Evening reception
Jude Kornelsen and Melanie McDonald
from the Centre for Rural Health Research

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Remuneration barriers were cited by participants as a particularly significant issue and include unsustainable start-up costs, an urban-centric remuneration structure and model of care, as well as the lack of a rural voice in funding decisions. Solutions include increased funding from the Ministry of Advanced Education and Training, including a start-up fund for rural midwives and the provision of vehicle mileage and gas funding based on catchment geography. Service contracts in low-resource environments would address remuneration for well-woman care, education, and outreach to meet the needs of rural communities. Additionally, professional associations and ministry negotiating groups must prioritize the involvement of midwives in all funding decision discussions. See Appendix 4 for remuneration model recommendations.

Travel barriers for rural midwives are underpinned by challenging geography and seasonal weather. For birthing women who travel for care, accommodations and social support in the form of liaison workers and doulas can mitigate travel challenges. Improved communication with BC Bedline can also enhance the care for women traveling to give birth. For rural midwives, one strategy for addressing travel challenges is seasonal selection of home birth clients.

Hospital and community barriers consist of challenges in articulating roles and responsibilities, particularly with nurses, within an inter-professional environment and lack of public information about midwifery. Solutions include making use of collaborative care documents and training (ex. MORE^{OB} and MCP²), a midwifery education tour across the province, and media outreach.

Policy making barriers centre on the need for greater professional support from and representation at the Ministry of Health and MABC. The participants suggested forming a Society of Rural Midwives, modeled after the Society of Rural Physicians, having an established rural representative in person at MABC and ministry meetings, as well as creating a research agenda on rural midwifery issues.

Steps forward include future meetings—the first being scheduled for October 2008, which will include Aboriginal representatives—ongoing discussion with key stakeholders, and the implementation of solutions to the most pressing challenges, namely remuneration.

Preface

Since the regulation of midwifery in BC on January 1, 1998, midwives have made steady progress in meeting the maternity care needs of more and more parturient women across the province. Although perhaps most noticeable in urban centres, inroads to practice have also been made in small urban and rural and remote communities. This is despite the considerable barriers rural midwives face, barriers distinct from those encountered by their urban colleagues and rooted in the unique geography, isolation, and low-resource settings characteristic of rural British Columbia.

The *Invitational Rural Midwifery Symposium* came out of growing recognition that, after 10 years of regulated midwifery and the concomitant gains achieved, the current model of care can now be refined to better meet the needs of rural midwives and the communities they serve. This became evident through our research visits across the province and discussions with the midwives who are currently living and working in rural settings, and was confirmed through dialogue at the symposium.

Although the primary objective of the day was the articulation of barriers to rural practice, the symposium was also about honouring and celebrating rural midwives and the contributions they make to rural communities. However, to truly honor the remarkable contribution of rural midwives we need to now focus our energy and attention on how to sustain practice within a context of low volume, potential lack of immediate access to specialist care and, for many, professional isolation.

The discussion that follows reflects our tentative first steps in achieving this sustainability. This meeting, however, was only the first part of what needs to be an on-going series of discussions between rural midwives, their professional association and college, policy makers, and the research community. To this end, we present the following proceedings as the foundation for a meeting with all key stakeholders who will contribute to this endeavour. We look forward to continuing the dialogue in October.

Respectfully submitted by

Jude Kornelsen, on behalf of the
Centre for Rural Health Research

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Message

from the MABC Rural Midwifery Committee

Rural midwives have been pioneers of universal access to midwifery care for over ten years in British Columbia. They have embodied the vision of the Midwives Association of BC by promoting the growth of midwifery in some of the most challenging and least desirable areas of practice in the province. While much of the vital political impetus that led to the formal establishment of midwifery within our health care system sprung from the urban centres, rural midwives have quietly led the way into outlying areas where establishing a midwifery presence has been met with considerable barriers. The groundwork for registered midwifery has been laid, in many rural areas, by community midwives whose grassroots work often spanned decades prior to government regulation.

In 2007, one of the outcomes of the contract negotiations was the formation of the Joint Policy Committee, which was created to discuss midwifery issues of mutual interest between the Ministry of Health and the Midwives Association of BC. One of the focal areas for discussion in these meetings has been sustaining and supporting rural midwifery practice.

Over the past eight years, the Midwives Association of BC and the College of Midwives have jointly hosted the Rural Midwifery Teleconference annually or bi-annually. This has been an active, engaging forum and networking opportunity for midwives working in rural and remote locations and the only organized venue for members of the rural midwifery community.

The MABC recognizes the importance of integrating and supporting rural midwives in its Strategic Plan for 2007-2010 and has also committed to having rural representation in its next rounds of contract negotiations. Now comprising a larger and growing presence in the professional body and on the MABC Board, rural midwives continue to seek more active and direct participation and greater self-determination in the policies that affect them.

During the early years of registered midwifery, the focus of attention centered on establishing the most basic 'ground zero' policies and protocols to launch midwifery into BC's health care system, a necessary and overwhelming task requiring innumerable unpaid hours of work for the province's newest practitioners. During this time, rural midwifery was a distant and often lost voice. After ten years of treading water in dedicated practice, rural midwives are coming into the spotlight. The professional body and the policy makers are recognizing that the crisis in sustainable maternity care has made rural midwifery an issue of great significance in the province.

The Rural Midwives of BC are pleased to support and provide their input into rural maternity research. In this way, their issues may be defined and articulated and their story may be told. As the Chair for Rural Midwifery in BC and on behalf of the MABC and the Rural Midwives of the province, I would like to acknowledge and express our appreciation to the Rural Maternity Care New Emerging Team for their outstanding work in this area and their contributions to rural midwifery practice.

Deborah Kozlick, RM
Chair, Rural Midwifery, MABC

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Agenda

June 19

- 4:00 - 6:00 PM Check into hotel
- 7:00 - 9:00 PM Dessert reception and social at the Indigo Bistro
(1st Floor, Sheraton Wall Centre)

June 20

Meeting in the Orca Room, Sheraton Wall Centre

- 8:00-8:30 **Continental Breakfast and Coffee**
- 8:30-9:00 **Introductions, Welcome & Overview**
- 9:00-10:00 **Discussion:** Prioritization of Barriers to Rural Midwifery Practice
- 10:00-10:30 **Presentation:** The Integration of Registered Midwifery into a Rural Maternity Care Delivery System, *Ilene Bell*
- 10:30-11:00 **Presentation:** Midwifery-Led Rural Maternity Care in BC: A Case Study on Saltspring Island, *Maggie Ramsey*
- 11:00-12:00 **Discussion:** Best Practices for Rural Midwifery: What is Currently Working in Rural Communities?
- 12:00-1:00 **Lunch**
Presentation: Preliminary findings from the Inter-professional Collaboration research project, *Jude Kornelsen*
- 1:00-2:00 **Presentation:** Rural midwifery in other jurisdictions: What can we learn? *Jude Kornelsen*
- 2:00-3:30 **Discussion:** Strategically addressing barriers to rural practice in British Columbia
- 3:30-3:45 **Break**
- 3:45-4:30 **Discussion:** Ministry of Health and Health Authorities
- 4:30-5:00 **Discussion:** Future meeting planning (October/November)

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Introduction

Since 1998, registered midwifery has been a maternity care option for women in British Columbia. Midwives provide individualized, family-centred, one-to-one care to birthing women and their families and practice on the principle of providing women with informed choice in childbirth. Currently in British Columbia, there are 32 community-based midwives practicing in rural areas. Due to a confluence of professional, financial, geographic, and legislative barriers, it is difficult for midwives to establish and maintain sustainable practices in rural communities. The *Invitational Rural Midwifery Symposium*, hosted by the Centre for Rural Health Research and MABC Rural Midwifery Committee, was organized to provide rural midwives with the opportunity to identify and communicate the barriers to sustainable midwifery practice in rural communities.

The following proceedings consist of two interwoven narratives that emerged from the symposium. “Barriers to Sustainable Rural Midwifery” thematically illustrate the specific barriers that rural midwives face, the potential solutions to mitigate these barriers, and the target decision makers who can facilitate positive change. Complementing each thematic section are “Midwives’ Voices,” narrative pieces from participants who shared stories of their practice experiences and challenges to sustainability.

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Barriers to sustainable rural midwifery

The goals of this symposium were to honour rural midwives and provide them with a venue to identify barriers to midwifery models of maternity care within a rural environment and the changes that need to occur to facilitate such models. Participants highlighted numerous challenges and, throughout the day, the Centre for Rural Health Research compiled and thematically organized these challenges into a list of barriers, solutions, and target decision makers. At the close of the symposium, participants were given the opportunity to review and confirm the information gathered in the barriers document. The following comprehensive thematic list represents rural midwives' practice challenges and provides a sketch of the barriers that must be overcome in order to make rural midwifery in British Columbia sustainable.

Sustainable rural midwifery care depends on the support of birthing women and the larger community of care providers. Guiding principles underpinning rural midwifery care include the prioritization of birthing women's needs and desires and the ability of midwifery to work alongside a larger system of health care delivery established in the province. Additionally, we must view the integration of midwifery as a long term process involving time, outcomes, and trust. Currently several barriers exist that challenge the sustainability of rural midwifery care. They are detailed in the following pages, as expressed by participants at the symposium.

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Rural midwives at the evening reception (left to right) Maggie Ramsey, RM (Salt Spring Island), Sheila Jager, RM (Campbell River), Michelle Cameron, RM (Lower Mainland), Sarah Hilbert-West (UBC Midwifery student, Quesnel), Jane Blackmore, RM (Cranbrook), and June Friesen, RM (President of MABC; partially obscured).

midwives' voices

It's just nice for us to get together. It's valuable and important to have support. Maybe we could do chart reviews together regularly and build mechanisms to support each other. Up until now we have had the rural midwifery teleconference, and it is difficult to do more because people can't leave their practices. We are just now getting to a point that we can trade off with partners and get time away. Meeting in person is great because with the midwifery teleconferences, we spend over half of the time spilling our guts and never have time to get to the point.

*We have to make a decision as a culture: do women deserve care during their maternity experience? If women deserve care then it is up to us as a society to provide this and should not be up to burnt-out, broke midwives. We are looking at things through the wrong lens. We should be trying to discover **how to sustain maternity care** in a community, it shouldn't be how are we going to sustain midwifery care. We talk about traveling over the mountains etc, the cost of gas is HUGE! Why are we providing women's health care on our backs? This is ludicrous!*

Professional barriers

Although many sustainability issues are common to midwives across British Columbia, there are particular challenges faced by rural midwives that their urban counterparts do not often encounter. For midwives practicing in 1:1 or 1:2 call groups, due to the lack of a larger professional cohort in their community, it is difficult to go off-call or find locums. If a locum is available, it can be financially draining to pay and find housing for her.

Rural midwives comprise nearly 1/3 of the province's total midwives, yet have limited representa-

tion in their professional association, the Midwives' Association of British Columbia (MABC), and are often unable to attend meetings in person due to the challenge of leaving their communities. This can make rural practice professionally isolating. Several suggestions were put forward to remedy this situation, recognizing the importance of such collegial support.

Barrier	Solution	Target Decision Maker
Inadequate locum coverage	Funding from MABC to cover locums and accommodation for rural midwives to travel to meetings every 2 months (potentially modeled after the Rural Locum Program for physicians)	MABC
	Provincial position for a midwife who does only locums	College of Midwives; MABC; Ministry of
Lack of organized peer support	Funding for face-to-face meetings	MABC; Ministry of Health
	Regional departments of midwifery for collaborative CME, chart reviews, and M&M rounds.	Regional Health Authorities
	Recognizing the importance for rural midwives of socializing with their colleagues	MABC
Challenges to the introduction of rural midwifery	Create and maintain dialogue between all key stakeholders involved in the care of parturient women in each committee.	Local medical advisory committee
	Have an established midwife assist in the integration process as a consultant/facilitator within the context of a regional Department of Midwifery (see above)	Regional Health Authorities

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midwives' voices

Historically, women in my area have often chosen to have their babies unattended or with unregistered midwives. I'm new to the community, and so is registered midwifery, so part of my practice is to reach out to these women and provide the community with education on midwifery and safe birthing practices. Also, because there is no medical care in my community—it's very isolated—I do a lot of 'well woman' care, as well as sex education at the lo-

There are a lot of unregistered midwives in our community. Sometimes we lose people to them when we don't go out on a limb and do a delivery in the middle of the forest in a log cabin with no

When clients mention they have considered the option of having a doula help them with an unassisted home birth, we are very clear that, as care givers, that is not within our comfort level and we won't be able to provide last minute back-up. This is around community safety. We have been very blunt with this. We can't support it.

Health service delivery issues

When women in a community are choosing to have unassisted home births instead of accessing local or referral hospital intrapartum care, it is often an indicator that local midwifery care is needed. Yet unassisted home births in communities where midwifery already exists can indicate a cultural barrier, in which women are choosing to birth outside of the system because of personal, cultural, or religious beliefs. Unassisted home births and unregis-

tered midwives can create significant practice issues for midwives in rural communities. Medical colleagues may confuse the difference between registered midwifery and unregistered/lay midwifery. Women who choose unassisted home births may not understand the scope of practice of registered midwives, the role that midwives play during labour and delivery, and the safety issues surrounding birth without trained support.

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Barrier	Solution	Target Decision Maker
Unassisted homebirths create ideological challenges for patient-midwife relationship	Provide prenatal and postpartum support to unassisted homebirth women	Midwives
	Engage in an informed choice/consent discussion with women choosing unassisted homebirth (potentially using the template of the Saltspring Island midwives' booklet, "Where should I have my baby?")	Midwives
Negative history of lay midwifery in community	Educate community on role of registered midwife	Midwives
	Educate community (including hospital staff) on role of registered midwives	Midwives
Many rural midwives close to retirement age	Funding for locum pool of established midwives to support new midwives in rural communities	MABC
	Alternative funding models to allow midwives to limit practice (ex. prenatal/postpartum care part-time practice)	MABC; Ministry of Health
Rigid model of practice		
Hospital has minimal pediatric capability causing increased transfers	Provide informed choice documents for women	BCPHP
Intermittent coverage for cesarean section back-up (often mid-labour)	Provide informed choice documents for women	BCPHP
	Create coordinated evidence-based guidelines on safety of birth without cesarean section back-up (as well as birth without epidural anesthesia or synthetic induction)	BCPHP



Evening reception
Ilene Bell, RM (Nelson) and Saraswathi
Vedam, RM (UBC Midwifery)

midwives' voices

When was the last time any of us have been to a conference that you didn't have to go to? We don't have the money or resources to get continuing education, which is important in keeping our skills fresh and up-to-date. We need to be stimulated and not stuck.

Access to continuing education is a HUGE barrier. Where is the funding? Who will cover my call? How will a pay for a locum if I can even get one? There should be better parity for rural midwives

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Education + continuing education barriers

Before entering rural practice, student midwives face many challenges in gaining adequate rural experience and rural mentorship. Preceptors also struggle with not receiving remuneration for the extensive mentorship they provide to students. Once in a rural community, if the hospital grants

the midwife privileges, new graduates face high start-up costs and significant student loan debt. Without incentives, many new midwives will not choose rural practice. Recruitment gaps will be felt the most in communities that have established midwives who are close to retirement.

Barrier	Solution	Target Decision Maker
Difficulty in accessing midwifery education for rural residents	Make courses available through rural colleges (ex. UVIC web-based nursing program, Northern Medical Program) for transfer to midwifery education program	UBC Midwifery Education Program; College of Health Disciplines
Lack of rural-specific education	Recognize the value of educating practitioners from rural communities (through targeted rural seats in Midwifery Education Program) to increase the number of midwives practicing in rural areas	UBC Midwifery
	Integration of rural-specific skills (ex. necessary to practice in isolated, low resource environments) into educational program	UBC Midwifery
	Integrate practical experience into first year of degree program	UBC Midwifery
	Rotating mentorship program	UBC Midwifery; College of Health Disciplines
	Inclusion of rural midwifery in Inter-professional Rural Placement Program to provide on the ground experience of rural practice	UBC Midwifery; College of Health Disciplines
Creating incentives for new graduates to enter rural practice	Established, formal mentorship program for midwives entering solo/new practice in a rural community	UBC Midwifery; College of Health Disciplines
	Increase number of bursaries and grants awarded; integrate student loan forgiveness program for serving rural communities with those in other provinces	Ministry of Advanced Education and Training
	Training, compensation, and travel expenses for preceptors	Ministry of Advanced Education and Training
Finding time/funding for CPD	Receive CPD funding from Health Authorities on par with other practitioners	Health Authorities; Ministry of Health
	Support from obstetric/pediatric specialists to have CPD funding pooled to include community midwives	Health Authorities; Ministry of Health

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Evening Reception
Maggie Ramsey, RM (Saltspring Island) and Sheila Jager,
RM (Campbell River)

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midwives' voices

Initially we didn't have a good relationship with the hospital. It took about one year to get hospital privileges. Many docs were concerned about midwifery in general because there was a history of bad experiences with lay midwifery care in the community. So, initially our privileges were refused due to pressure from the doctors. Later, when our privileges were granted, we had our hospital orientation on Christmas Eve when no one was around. It was all very hush hush. The hospital arranged for us to be oriented by a

After we gained privileges, I was terrified for my first birth at the hospital. I was worried about it for weeks. It caused a lot of stress. But on the day of the birth itself, it didn't matter anymore. It wasn't a big deal, it wasn't about me, and it wasn't a really momentous experience. It was about the woman. Just another beautiful, simple

Privileging barriers

A number of midwives who have tried to enter rural practice have been refused hospital privileges. These decisions have been based on physicians' and decision makers' concerns about the safety of midwifery and the sustainability of physician-led mater-

nity care in the presence of a midwife. Communities can learn from the experiences of successful midwifery integration and the benefits of introducing midwifery. (See Ilene Bell's case study of Nelson, BC—Appendix 1.)

Barrier	Solution	Target Decision Maker
Hospitals not granting privileges	Engage in communication with all key stakeholders before beginning privileging process, including College of Midwives and MABC if needed	Midwives
	Become familiar with rules and regulations surrounding privileging process for local Health Authority or service delivery area	Midwives; Health Authorities
	Consult with communities and midwives who have successfully integrated midwifery into local maternity care	Midwives
	Gain support from experienced midwives in neighbouring communities who understand community context	Midwives
Cannot use "courtesy privileges" in referral centres because of distance from hospital	Work with local medical advisory committee (LMAC) in referral community to establish appropriate protocol for "courtesy privileges"	LMAC; regional medical advisory committee (RMAC)

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Evening Reception with rural midwives and key stakeholders





Evening Reception

(left to right) Petra Pruiksma, RM (Roberts Creek); Karen Vida, BC Perinatal Health Program; Marty Willms, Interior Health Authority; Saraswathi Vedam, RM (UBC School

midwives' voices

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One of the worst things is that we don't get paid for a labour and delivery if we have to transfer the patient to specialist care. Since our hospital has only a primary care, level 1 nursery, complex births have to go out. I am guaranteed to lose about \$10,000 each year because of needing to send babies to bigger facilities.

No matter how many deliveries we have each month we are always on call. The current model of payment does not serve a small community because we are full-time whether you like it or not. This is really an issue as we have gotten older, as we wish to spend more time with grandchildren. We would like to move to a different model of payment that reflects what we do in terms of our deliv-

Maternity leave is a huge issue. New midwives don't want to go to a new community with no social or community support and then think about losing for all of the months when you need a mat

Remuneration barriers

Rural midwives identify insufficient funding as the greatest barrier to sustainable practice. Many rural communities rely on midwives to provide care over great distances. Due to barriers of distance and perception of lack of recognition as a distinct group, rural midwives often lack representation at discussions on funding and remuneration. Participants in this symposium expressed the importance of a revised funding model, including start-up sti-

pend, maternity leave, and pay for their extended scope of practice and service to large catchments, which would better meet the unique needs of rural practice. Sustainable rural midwifery care is currently contingent on stable physician care in many communities. To this end, on-call funding for physicians doing maternity care has been proposed (MOCAP; see Appendix 4).

Barrier	Solution	Target Decision Maker
Unsustainable start-up costs	Within the fee-for service model: Initial start-up stipend to begin practice (based on Ontario model) of at least \$3000 at start and per month	Ministry of Health
	Reduced professional fees for first year of practice (currently \$5200 annually)	BCMA
Unsustainable remuneration structures (urban-centric)	Salary or service contracts to cover well-woman care, education, and outreach to meet the needs of rural communities and account for low volume	Health Authorities
	Limited fee for service billings based on special circumstances (i.e. an assessment while on call)	Ministry of Health
	Payment for "physician consults" (i.e. acting as pediatric attendant at cesarean births)	Medical Services Plan; Ministry of Health
	Maternity leave	Ministry of Health
Lack of rural voice in funding decisions	Having an established rural representative at meetings (in person, not by phone), by funding locums plus accommodation/travel for rural midwives	MABC
	Fund training for successful negotiation strategies	MABC
Model of care	Funding for course-of-care regardless of pregnancy outcome/transfer	Ministry of Health; MABC
	Alternative funding for inter-professional care	Ministry of Health
Travel expenses over rural catchment	Provide vehicle, mileage, and gas funding based on community and regional criteria	Health Authorities
	Provide rural allowance to rural midwives	Ministry of Health; MABC

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midwives' voices

I provide coverage to a very large rural catchment with the farthest community about 350 km away. When I go to home births, I don't get any money to cover the cost of travel and it's quite expensive now with gas and my four-wheel drive vehicle. I often don't have another midwife to back me up. I'm supposed to take a second attendant, and I'm usually able to bring a nurse, but some-

We have women fly in from all over to get midwifery care—Bella

In our practice we have women coming from a very extensive area to access midwifery care—as far as 2 1/2 hours away over mountains and lakes. Lots of these women have no other choice because their communities have lost maternity care. It makes it difficult for us to take them on as home birth clients from October to April, though, because of the roads and weather. I have been there and

We have a really good rapport with the PHN's in neighbouring communities,. We know them by first name and call them every time we send one of our patients home. Transfer of information back to the community is very important. Electronic records need to be BC wide, because as soon as a baby is transferred to BC

Travel barriers

In many rural communities birthing women must often leave their homes for intrapartum midwifery services or during labour and delivery if the need for tertiary services arises. Ensuring sufficient care

for these women, however, can be extremely difficult due to distance, seasonal weather, communication barriers with BC Bedline, and lack of support resources for vulnerable women.

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Barrier	Solution	Target Decision Maker
Supporting women who must travel long distances for care	Accommodations Assistance Program (based on Travel Assistance Program): long-term rental hotels with kitchens and room for extended family	Health Authorities
	Establish liaison person (midwife, PHN, hospital social worker) to facilitate travel, documentation, and continuity of care for patients traveling for care	Health Authorities
	Introduce traveling midwives/nurses who can provide pre and postnatal care to small, isolated communities	Health Authorities
	Publicly fund doulas to travel with women who must leave their communities	Ministry of Health
Weather/ geography impeding travel	Seasonal selection of home birth clients	Midwives
BC Bedline not well-informed about rural practice	Have meetings with BC Bedline to educate them on rural challenges, map of communities, role of midwives; learn what data BC Bedline works from	MABC Rural Committee; BC Bedline
	Provide one-page form to accompany patient chart that outlines woman's history, care plan	Health Authorities; BCPHP; Midwives



Presentation by Ilene Bell, RM, Nelson

midwives' voices

The hospital community initially reacted to the introduction of maternity care with confusion. Nobody knew what to do, basically. They were haunted by shadows from the past—experiences from unregulated midwifery. Care providers were coming from a place of hearing stories of women attempting unassisted or lay midwifery home births and coming in to the hospital with the baby's feet hanging out, or ruptured membranes at home for 3 days. Even though most folk knew that some stories weren't true, the sto-

Even the hardest do fall, but it took years for us to get accepted

In a rural community you have to find ways to be friends with the other care providers. You know, chat with the nurses during a quiet point in the delivery and finding common ground on a personal level. If the midwife is down the hallway with the door closed, then

We never know if there's going to be cesarean section back-up in our community. Our anesthetist and surgeon won't come in if they're off call, and we don't have 24/7 c-section back-up. Sometimes a woman will be in the middle of labour and there is the looming possibility that she may need a cesarean, but the anesthetist will go off call and we'll have to ship out. Also the physicians like to go out of town without much notice, so we're left day-to-

Hospital + community barriers

For existing rural midwifery practices, hospital activities and nursing shortages can cause barriers to practice. Communication is central to any successful inter-professional maternity program. Patients need to be informed of choices available to them, care providers need to be aware of their colleagues' professional roles, and all stakeholders must collaborate to put birthing women's needs first. Communication and trust-building strategies can help build strong inter-professional programs.

Despite the fact that midwifery has been regulated and publicly funded in British Columbia since January 1, 1998, many women and families are still

unaware of some of the fundamental tenets of the model of care, such as choice in place of birth. Additionally, many women do not know that access to midwifery care is provided through their medical insurance coverage.

When a midwife enters a rural community to begin practice, there can be significant social barriers from her local medical colleagues, particularly safety and medico-legal concerns from doctors and nurses. Successful integrated practice requires time and the development of inter-professional trust. Specific professional barriers noted by participants are listed below.

Barrier	Solution	Target Decision Maker
Nurses' lack of training or knowledge of midwifery	Make use of existing collaborative care documents (ex. MCP ²)	MoreOB; Health Authorities
	Consider inter-professional education and training through established programs (ex. MoreOB).	MoreOB; Health Authorities
	One-page patient care plan can help nurses feel more comfortable about midwife's care	Health Authorities
Confusion of nurses over roles	Education on midwifery care and the roles and responsibilities of each profession; continued dialogue	Health Authorities; Midwives
Lack of public information about midwifery	Road show to communities without midwifery, with representatives from College of Midwives, MABC Rural Midwifery Committee, UBC Midwifery School, and BC Perinatal Health Program (BCPHP). Provide public education; recognize 10 years of registered midwifery in BC.	Ministry of Health and key stakeholders
	Information sessions in high schools/career days	Ministry of Education; UBC Midwifery
	Media outreach to educate the public about midwifery care and scope of practice	MABC
	Educate public that communities can provide in-trapartum care, through midwifery, in the absence	MABC

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Midwives at the symposium
(left to right) Joanna Nemrava, RM
(Maple Ridge); Maggie Ramsey, RM
(Saltspring Island); Leah Barlow, RM
(Creston); Michelle Cameron, RM
(Surrey); Jane Blackmore (Cranbrook).

midwives' voices

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There is no professional body for rural midwives to turn to. Officially there is nobody. I am paying a lot of money for my association but I would never turn to them. Urban midwives may have great intentions, but they don't understand rural practice. Sitting on a joint rural-urban MABC committee can be frustrating, because they just don't get it. This is not unique to midwifery, this is with all of the professional associations. Rural life is so different from ur-

As well as Aboriginal midwives, we should have funded doula care for Aboriginal women—especially those who have to leave their communities to give birth. That could help bridge the culture gap.

Historically as midwives we have been so grateful that we have been 'able' to practice, however we need to turn this thinking around. It needs to be policy makers' responsibilities to provide women with the care they deserve; it shouldn't be on our backs. We are constantly being ambassadors and educators. This is unac-

Policy making barriers

Rural midwives need greater professional support than any association currently provides. Rural practice barriers are complex and intersect with maternity system challenges faced by other care providers. Participants at this symposium felt a **Society of Rural Midwives** would better represent their

unique needs, facilitate improvement in rural midwives' practice and professional lives; provide rural midwives with a collective, provincial voice; provide leadership; and promote sustainable rural midwifery.

Barrier	Solution	Target Decision Maker
Uniqueness of local circumstances	Solutions that are locally defined by all key stakeholders	LMAC
Inadequate rural midwifery representation at Ministry of Health and MABC	Having an established rural representative at meetings (in person, not by phone)	Midwives
	Develop a research agenda based on rural midwifery issues and solicit assistance from RM-NET at Centre for Rural Health Research for evidence to inform decision making	Midwives; RM-NET
	Establish a Society of Rural Midwives modeled after the Society of Rural Physicians of Canada to provide midwives with status, venue for refining	Midwives

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Aboriginal midwifery

Aboriginal midwifery representatives were invited to the symposium but regrettably could not attend due to schedule conflicts. Future meetings of rural midwives must have Aboriginal representatives present in order to learn of the barriers unique to Aboriginal rural families and the midwives who serve them. Existing research indicates that Aboriginal rural women are at greater risk than their urban counterparts of experiencing poor childbirth outcomes and heightened financial and social stress due to birthing away from their family, community, and culture. Historically, Aboriginal women

in British Columbia have given birth close to home with the support of experienced women in their communities or with midwives. With the introduction of regulated midwifery, greater efforts must be made on the part of the Ministry of Health and associated decision makers to facilitate training of Aboriginal midwives, with particular attention to the cultural needs of Aboriginal student midwives, the importance of training close to home in rural communities, and the unique issues that Aboriginal birthing women face.

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Appendix 1

Integration of Midwifery into a Rural Community

Case Study: Nelson, B.C.
Ilene Bell

1



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Issues for Rural Maternity Care

- Fewer Family Physicians are providing maternity care
- Rural Communities are losing maternity care
- When women have to travel to give birth, newborn outcomes worsen
- Women who cannot give birth in their own communities face emotional, social, and financial difficulties
- Poor women are the most disadvantaged.

3

Challenges to Establishing New Rural Practices

Midwives' Concerns

- Isolation
- Economic viability
- Professional relationships

Professional Community Concerns

- Responsibility
- Quality of care
- Comfort with values, competence, care approach of an unknown profession

4

Objectives of this Study

- Identify challenges to multidisciplinary collaboration and investigate how these challenges have been met
- Explore the impact of the inclusion of registered midwives on all involved practitioners
- Include the perspective of midwifery clients

5

Methodology

Qualitative Study
Subjective
Case Study

Insider View
Participant Input

- 3 preliminary individual interviews (1 nurse, 1 M.D., 1 consumer
- 12 interviews: 7 individual, 6 focus groups
Included : 9 nurses, 1 nursing supervisor, 1 Public health Nurse, 1 obstetrician, 1 paediatrician, 2 family doctors, 10 midwifery clients
- 1 follow-up interview (2 nurses)

6

Nelson, B.C.

- Population: 9,800
- 412 miles from Vancouver, 390 miles from Calgary
- 42 miles from Kootenay Boundary Regional Hospital, Trail
- Kootenay Lake Hospital March 2007- April 2008
 - 350 deliveries (up from 290 5 years ago)
 - 120 midwifery deliveries (25 at home)
 - up from 60 births/year ten years ago
- 1 obstetrician, 1 pediatrician, no general surgeon
- 3 close to full-time midwives, 1 part-time midwife
- unknown number of non- registered midwives practicing

7

Initial reactions

Confusion
Shadows from the past
Grief
Under Threat
Anger
And.....open- mindedness

8

Confusion

“ Nobody knew what to do, basically...”
(nurse)

I didn't fully understand their scope of practice”....

“ I know they've written the exams but still , on the ground, we weren't sure about the skill set”

“ I think we need to feel it out with every new practitioner, don't we. We have to get to know the players “

9

Under Threat

“it's going to interfere on our turf” - nurse

- *“we're used to having control over our labour and deliveries. Our moms would come in and we were in charge...we did everything for them...all of a sudden we've got people coming in and saying, oh no, they're going to take over the whole thing”*

- *“...it was a huge threat in the beginning because they were going to do what we do.”*

10

Grief and Anger

"I went through a grieving process of letting that go, and I did, and then I embraced the midwives"

"I loved being a part of the coaching, that's when I'm at my best to be with my moms. And giving that up was really hard."

"I think there was a lot of anger for some people because they came on the floor, so it was like the midwives have to do it, everything themselves..."

"...and the simplest things ... The midwife didn't wash the basin out right ... or she didn't dump the linen ... The nurses were finding a place to focus."

11

Shadows from the Past

"it was a horror show sometimes, just a horror show"

"it was pretty scary because there were a lot of lay midwives working in the community and we were the rescue people...." -Family Physician

"We were coming from the history... of just hearing the stories in the community, and you only heard the bad stories, you don't even know if they are true stories. You just heard stories" - Nurse

"There's been a lot of wacky midwifery in the community, there's still a lot of wacky midwifery in the community." - Midwife

12

Open-Mindedness

"I knew that many of my female patients who were pregnant expressed an interest in seeing midwives"

"I was open-minded because I knew a number of the midwives who had been practicing as lay midwives." - Family Physician

"I actually welcomed it becoming legalized and licensed ...for the one reason that it would be above ground and not underground. With a college and accountability...So I was excited about it."

13

Factors for Change

"They've garnered the trust of their medical colleagues, they've garnered the trust of the nurses, and obviously, they have the trust of the patients" - Obstetrician

Time, Outcomes, and Trust

Talking It Out

Relationships

Policies and meetings

14

Time, Outcomes, Trust

"It was years, it didn't happen overnight ... and there are still some co-workers that are sticky about the situation" – R.N.

"If a patient was being assessed by the midwives and they were phoning for an opinion, we realized that their assessment was accurate and that makes it easier..."

"I think more than anything time, and a commitment on the part of the midwives. I tell you they were committed because it was a somewhat hostile environment they were coming into."

"At the end of the day, if they've got good out- comes ... then we are doing something right."

15

Talking It Out

"...an open dialogue, no hidden agendas ... it wasn't about midwives, it wasn't about doctors, it was about women"

"I had a few times when there was a total misunderstanding And I was responsible for it one of the times. And we were able to clear it up by calling and talking and saying 'Oh Boy!'... and going back and forth." – R.N.

"I remember one doctor and one midwife ... she just had to stand her ground and she did well because this doctor was very difficult and, of course, he was always right. So to see that – Right on, you're not backing down." – R.N.

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Relationships

"we realized that they had two eyes, two arms, and they ate with a fork like we did...and they weren't from Mars"

"I don't know what would happen if I were in a bigger place with a bigger staff because here you know we are talking about a limited number of people that I needed to find some way of being friendly with...."

"It's been a major project for me to build those relationships." - Midwife

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Meetings and Policies

"Questions were answered by sitting side by side at meetings and having an open dialogue"

"talking to them...and realizing that there was a considerable overlap in what they did and what we do..."

"it was just reassuring to know that they recognize their limitations, that they acknowledge that they were part of the team, that they weren't solo renegades"

"one of the policies was how to resolve conflict and it was actually laid out in an algorithm ... I don't think we ever used it but it was there."

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Roles and Responsibilities Black and white?

"If a patient is having an intervention that's beyond their scope, we just write who is responsible ... black and white." - Family Physician

"They would have to do exactly what the nurses have to do through BCRCP guidelines. It states right there in black and white...."

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Or.....Shades of Grey

"even now to this day, when am I responsible for their patient?" - R.N.

"we wanted the roles to be cut and dried."

"Yes. And we couldn't do that. To say this is my area and this is your area. But that didn't work so well." - R.N.

"so ignoring the rule and doing what we wanted to do really worked well for us for quite a long time." - Midwife

"the emotional wastage of the situation, trying to figure out where you are at. Because you are frustrated, because you're in the dark, not knowing ... when there's a doctor we know exactly what we're supposed to do." - R.N.

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Grey Issues

Charting

Nurses participation in Labour/Delivery

Clean-up

Physician responsibility / Consultation

21

Sharing a Chart

"when it's a doctor delivery, it's basically our chart and we take care of it. When it's with the midwives, we're sharing the chart and sometimes I don't know how to share."

"And I keep thinking, it's your patient and you should be charting the way I chart, but you're not. Or, sometimes you're not."

"...it's like sharing a journal, it's weird and it gets messy sometimes." - R.N.

22

Workload Relief vs Desire for Inclusion

"we're getting spread thinner all the time" – R.N.

"there's always stress on the floor, I find. I'm actually relieved, it's less stressful for me to have a midwife." – R.N.

"I would like to be in that room more but I can't be." – R.N.

"I have difficulty not knowing what is going on down that hallway." – R.N.

"we'd love to be on their radar"- PHN

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Advice to other Communities

"I would encourage other communities who are considering integrating midwives to be open minded and to do it. It's a win win for everybody" – Family Physician

"they bring choice and I think they bring safety ... for those people who wouldn't have had care at all."- Pediatrician

"we need people to do deliveries, we're a busy site" - Pediatrician

"I worry a lot more about women who go home without midwives." - R.N.

"a key cog in the wheel" – Family Physician

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Appendix 2

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Rural Midwifery Care in B.C.



Towards Sustainability

Jude Kornelsen, PhD, Department of Family Practice, UBC/VCHRI & Co-Director, Centre for Rural Health Research

RURAL MIDWIFERY SYMPOSIUM • June 20, 2008 • Vancouver, BC



Objectives

- > Report suggested options for models of rural midwifery care; and
- > Suggest funding incentives to strengthen rural midwifery practice including review of solutions from other jurisdictions



Funded Projects

- Rural Women's and Care Providers' Experiences of maternity care (& implications for policy) (CIHR/SWC)
- Conditions necessary for sustainable care (CIHR)
- The training and practice experiences of GPS (MSFHR)
- The outcomes of women who need to travel to receive care (CIHR)
- Pathways to inter-professional collaboration in rural communities (CIHR)
- A measure of the stress of rural parturient women (CIHR)
- An Economic Cost analysis of rural maternity services (CIHR)



Rural Maternity Care New Emerging Team

Barriers to sustainability



Rural Maternity Care New Emerging Team

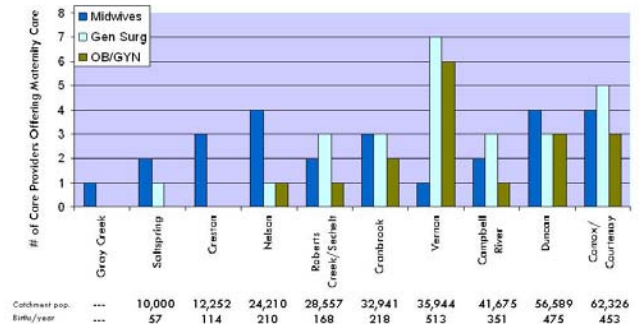
Maternity service closures in BC since 2000

Kimberly & District Hospital	May 1, 2002
Sparwood General Hospital	May 1, 2002
Arrow Lakes Hospital (Nakusp)	
Castlegar & District Hospital	March 1, 2002
Summerland General Hospital	June 2000
South Okanagan General Hospital (Olive)	April 1, 2000
Nicola Valley General Hospital (Merritt)	April 1, 2001
St. Bartholomew's Hospital (Lytton)	April 1, 2001
Ashcroft & District Hospital	April 1, 2002
Fraser Canyon Hospital (Hope)	April 1, 2002
R.W. Large Memorial Hospital (Bella Bella)	2001
Saanich Peninsula Hospital (Saanichton)	May 1, 2002
Masset Hospital (Queen Charlotte Islands)	May 2002
Mission Hospital	2002
Alert Bay	2002
Port Hardy	2002

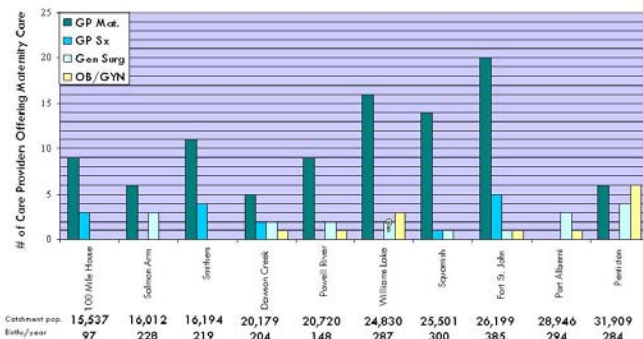


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Communities with Midwives



Like-Sized Communities without Midwifery



Current and Potential Rural Midwifery Practices



Suggested Models of Midwifery Integration

- Integrated Physician/Midwifery practice with midwifery outreach
- Collaborative Call + Community Midwifery Practice
- Collaborative Call + Community and Outreach Midwifery Practice
- Independent Midwifery and Physician Practices
- 1-1 Physician Care and Community Midwifery Practice



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Model A: Integrated Physician/Midwifery practice with midwifery outreach

Description	Funding	Perceived Benefits	Perceived Costs
<ul style="list-style-type: none"> Shared call between physicians and 1 or 2 midwives, including on call prenatal, labour and delivery and postpartum Prenatal and postpartum in clinic Random assignment of women to provider based on call rota No independent/community based midwifery practice (no home births) Provide outreach and education to women and care providers in hospital catchment under service contract option 	<ul style="list-style-type: none"> Option 1: Pooled fee for service Option 2: Physician fee for service, midwife service contract 	<ul style="list-style-type: none"> Increased call coverage for physicians Increase sustainability Midwifery care in community Enhance image of hospital maternity Repatriation of women currently going elsewhere for midwifery care Gentle entrance of midwives into community 	<ul style="list-style-type: none"> Recruitment of midwife Midwives cannot do home birth under this model Midwives limited scope of practice Concerns about midwives financial sustainability (only if pooled fee for service billing model) No choice to opt out of midwifery care in call group

Feasibility Issues

- Regulatory Issues
 - No home birth
 - No continuity of care
 - Short prenatal visits (should be 45 min to 1 hour according to college)
 - No in-home postpartum care
- Professional Issues
 - Recruitment & retention of midwives
 - Salary/contract position
 - Attractiveness of position to midwives
 - Ability to find a midwife to practice under contracted scope of practice



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Model B: Collaborative Call + Community Midwifery Practice

Description	Funding	Perceived Benefits	Perceived Costs
<ul style="list-style-type: none"> Integrated call between physicians and midwives Community based midwifery practice including home birth (2 midwives minimum) - Maternity nurse as potential second attendants for home births Group prenatal care led by midwife and GP (Centering Pregnancy Model) Collaborative postpartum care (PHN's, lactation consultant, midwives and physicians) 	<ul style="list-style-type: none"> Option 1: Pooled fee for service Option 2: Partial pooled fee for service + service contract (i.e. 0.4 for call group work and outreach) Option 3: Physician fee for service, midwife service contract 	<ul style="list-style-type: none"> Increased call coverage for physicians Increased sustainability Midwifery care in community Enhance image of hospital maternity Reparation of women currently going elsewhere for midwifery care Availability of home birth in outlying communities Innovative models of prenatal and postpartum care Collaborative learning between care providers Increased choices for women 	<ul style="list-style-type: none"> Recruitment of midwife Midwives' limited scope of practice No choice to opt out of midwifery care in call group Challenges to sustainability of midwife doing call group call + independent practice call

Feasibility Issues

- Regulatory issues (same as Model A)
- Professional issues (same as Model A)
 - The feasibility of fee for service billing
- Logistics of shared care led by GP and midwife
 - Different approaches to informed consent
 - Women traveling long distances to attend Centering Pregnancy
 - Conceptual barriers to Centering Pregnancy for vulnerable population of moms
- Communication
 - For Centering Pregnancy: physician and midwives developing shared attitudes towards care



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Model C: Collaborative Call + Community and Outreach Midwifery Practice

Description	Funding	Perceived Benefits	Perceived Costs
<ul style="list-style-type: none"> Integrated call between physicians and midwives Community based midwifery practice including home birth (2 midwives minimum) - Maternity nurse as potential second attendants for home births Group prenatal care led by midwife and GP (Centering Pregnancy Model) Collaborative postpartum care (PHN's, lactation consultant, midwives and physicians) Midwifery outreach to hospital catchment for prenatal care + care provider education 	<ul style="list-style-type: none"> Option 1: Pooled fee for service Option 2: Partial pooled fee for service + service contract (i.e. 0.4 for call group work and outreach) Option 3: Physician fee for service, midwife service contract 	<ul style="list-style-type: none"> Increased call coverage for physicians Increased sustainability Midwifery care in community Enhance image of hospital maternity Reparation of women currently going to elsewhere for midwifery care Availability of home birth in outlying communities Innovative models of prenatal and postpartum care Collaborative learning between care providers Increased choices for women Outreach to under-served communities 	<ul style="list-style-type: none"> Recruitment of midwife Midwives' limited scope of practice No choice to opt out of midwifery care in call group Challenges to sustainability of midwife doing call group call + independent practice call Increased travel time/time away from community practice for midwives

Feasibility Issues

- Regulatory issues (same as Model B)
- Professional issues (same as Model B)
- Logistics of shared care led by GP and midwife (same as Model B)
- Communication (same as Model B)
 - For outreach: communication plan between midwives and care providers in community (i.e. PHN's)
- Travel
 - Cost (financial and time) to midwives
 - Remuneration for travel
 - Feasibility of doing home birth in outlying communities
 - Road conditions in the winter



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Model D: Independent Midwifery and Physician Practices

Description	Funding	Perceived Benefits	Perceived Costs
<ul style="list-style-type: none"> Call group staffed by physicians Independent community-based full scope midwifery practice Minimum 2 midwives 	Fee for service	<ul style="list-style-type: none"> Increased choice for women Midwifery care in community Enhance levels of care in the regional hospital (midwives/ doctors/ OB's/ pediatrician) Reparation of women currently going to other places for midwifery care Ability to meet the needs of orphan patients from outlying communities 	<ul style="list-style-type: none"> Questions around sustainability of physicians without on call funding Potential for decrease in physicians' patients

Model E: 1-1 Physician Care and Community Midwifery Practice

Description	Funding	Perceived Benefits	Perceived Costs
<ul style="list-style-type: none"> 1-1 GP care for women Full scope community midwifery practice 	Fee for service	<ul style="list-style-type: none"> Increased choice for women Continuity of care for women accessing either model of care 	<ul style="list-style-type: none"> On call requirements for physicians Lack of flexibility to incorporate orphan patients into practice models



Rural Maternity Care New Emerging Team

Proposed start-up stipend for rural midwives



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Model for Rural Midwifery Start-up Funding

Rural midwifery practice = 40 births/year (3.3 births/month)
 Billing paid per trimester = \$225 each for first, second, third trimester
 Labour/delivery (L&D) fee = \$950

Average established midwifery practice income

Course of care (per client)	Fee
First trimester	\$225
Second trimester	\$225
Third trimester	\$225
Labour and delivery	\$950
Postpartum	\$950
Total	\$2575

\$2575 x 40 clients
 12 months
 = \$8583

Midwifery practice once underway → Income of \$8583 per month (before expenses, taxes, and deductions)



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Funding Support

- All midwives who commit to set up a practice in a rural community, where a community need exists, should receive a start-up stipend.
- Additional funding may be required for travel due to the geographic realities of providing home based care in rural catchments.
- Funding must be made available for locum coverage in rural communities to increase sustainability of permanent care providers.



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Anticipated Outcomes

- The introduction of start-up funding for rural midwives will increase the feasibility of midwifery practice in communities that have never had midwifery care.
- Travel subsidies will contribute to the fair remuneration of midwife travel in dispersed rural catchments, enabling them to do outreach to women whose communities are under-served due to hospital closure.
- Funding support for rural midwifery locums will increase the sustainability of rural midwifery practice due to providing time off call and away from the community.



Rural Maternity Core New Emerging Team

Aboriginal Midwifery



Rural Maternity Core New Emerging Team

Learning from Other Jurisdictions: International Solutions to Increase the Sustainability of Rural Midwives



Rural Maternity Core New Emerging Team

Remuneration

- **Proposed annualized salaries** (pro rata) for midwives (Queensland, [Australia](#))
 - No follow-up reports on the integration of the suggestion or its success
- **Self employed midwives contracted** by a local health authority to provide care for a predetermined number of patients (Albany Midwifery Practice, [UK](#))
 - Practice is self-managed and is responsible for payment of salaries, wages and benefits



Rural Maternity Core New Emerging Team

Costs

In a rural setting travel expenses, equipment and time spent traveling between clients' home is all associated with a higher cost than in an urban setting

- **Rural Bonus Funding** ([New Zealand](#))
 - Funding is allocated according to "how rural" a midwife's practice is, as based on factors such as isolation, distance to backup and availability of on-call cover



Rural Maternity Core New Emerging Team

Maintenance of Skills

Rural health practitioners face unique information barriers such as isolation, inadequate library access, and lack of time, equipment, and Internet infrastructure

- **E-mentoring** ([New Zealand](#))
 - New graduates or rural and remote midwives correspond with other midwives and professionals via internet or phone



Rural Maternity Core New Emerging Team

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Maintenance of Skills

•Telemedicine (UK)

- Allows specialists to review test results and meet with women without having to be physically present
- Fast, convenient, cost effective
- May be an effective form of inter-professional collaboration in communities with birth rates too low to support the employment of a specialist



Continuing Education

Rural midwives may benefit from skill maintenance at **regular intervals in a larger hospital**

- Midwives who spent time working in a higher-level maternity unit or hospital had lower perinatal mortality rates in their practice compared to midwives who did not undertake this training ([Australia](#))
 - cost of funding training and replacing a midwife while she is away may be a problem



Recruitment and Retention of Rural Midwives

• Rural Bonus Funding (New Zealand)

- For GPs funding resulted in reduced on-call workload, increased recruitment of replacement staff, improved educational opportunities (has not been evaluated in midwifery)

• Recertification Alternatives (New Zealand)

- In recognition of rural midwives' limited access to some professional activities, Midwifery Council invites midwives to suggest alternative professional activities to demonstrate professional competence and ongoing maintenance of skills



ENGLAND

- 22,770 practicing midwives (2007)
- 629,364 births (2006)
- UK midwife legislation in 1902
- Involved in births in community, birthing units and hospitals
- Homebirths ~3% (2005-6)
- 64% of hospital births midwife attended (2005-6)



SCOTLAND

- 3,938 practicing midwives (2007)
- 55,690 births (2006)
- UK midwife legislation in 1902
- Involved in births in community, birthing units and hospitals
- Homebirths <1% (2000)
- 23 stand-alone midwife-led units (2000)
 - 14% of births



NORWAY

- 1,970 members of midwife association
- 58,500 births (2007)
- Midwife legislation in 1801
- Involved in births in community, birthing units and hospitals
- Provide most care for low-risk women, work in close partnership with GPs and obstetricians



NEW ZEALAND

- >2,500 members of midwife association
- 58,727 registered births (2005)
- Autonomous profession since 1990
- >78% of women have midwife as lead maternity carer (LMC)
 - In some regions midwife as LMC in up to 96% of cases
- Involved in births in community, birthing units and hospitals
- All birth facilities expected to have a midwife on call and physician LMCs required to have midwife support



Rural Maternity Care New Emerging Team



AUSTRALIA

- 18,058 registered midwives in New South Wales (2007)
 - National registration not yet in place
- 165,900 registered births (2006)
 - 87,336 births in New South Wales
- Midwives and GPs work independently but in cooperation with specialist obstetrician, GP-OBs or obstetrical unit
- Involved in births in community, birthing units and hospitals



Rural Maternity Care New Emerging Team



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Appendix 3

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Name	Place of Practice
Reception and Symposium Attendees	
Leah Barlow	Creston
Ilene Bell	Nelson
Jane Blackmore	Cranbrook
Michelle Cameron	Surrey
Karin Gerlach	Prince George
Sarah Hilbert-West	UBC Midwifery student
Sheila Jager	Campbell River
Deborah Kozlick	Courtenay
Joanna Nemrava	Maple Ridge
Shannon Norberg	Vancouver
Sadie Parkin	Courtenay
Sylke Plaumann	Gray Creek
Petra Pruiksma	Roberts Creek
Maggie Ramsey	Saltspring Island
Reception Attendees	
Kim Campbell	RM, Abbotsford
June Friesen	President, BC Midwives Association
Patty Keith	Perinatal Lead, Vancouver Coastal Health Authority
Jane Kilthei	Registrar and Executive Director, College of Midwives of BC
Saraswathi Vedam	Director, UBC Division of Midwifery
Karen Vida	BC Perinatal Health Program
Marty Willms	Perinatal Lead, Interior Health Authority
Research Team	
Jude Kornelsen	Principal Investigator
Melanie McDonald	Research Assistant
Sarah Munro	Writing Support

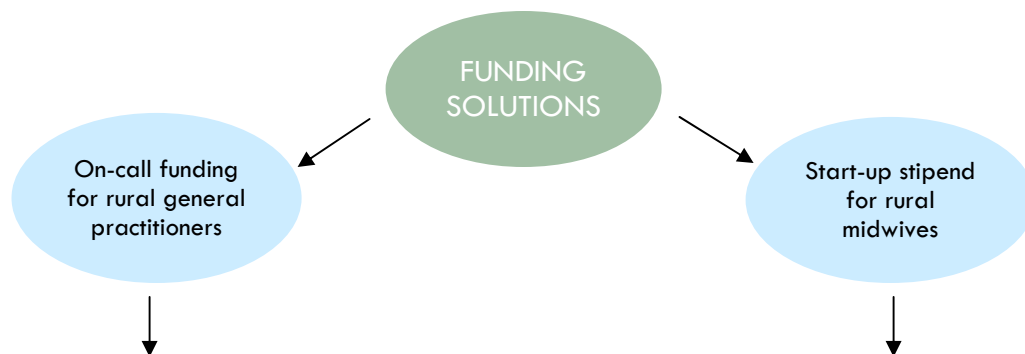
Appendix 4

Rural care provider funding recommendations

Rural Maternity Care New Emerging Team

Rationale

- Rural primary care practitioners are leaving maternity practice due to opportunities for remuneration in other specialty call groups and the lack of remuneration for obstetric call.
- Care providers in referral communities are now responsible for being on call for the deliveries of “orphaned patients” due to the closure of services in satellite communities. This is in addition to the deliveries of women in their local practice.
- The introduction of midwives to rural communities will contribute to meeting the needs of rural birthing women.



Guiding Principles

1. Rural maternity care has been dis-incented due to competing on-call payments.
2. There needs to be fair remuneration in rural communities in order for maternity care to be competitive with other on-call groups.
3. On-call remuneration for primary care maternity call must be implemented province-wide.

1. Midwives face onerous start-up costs in new communities.
2. There needs to be fair remuneration for midwives starting practice.
3. This solution comes from a rural evidence base; it may be applicable in an urban environment.

Recommendations

Rural Primary Care Maternity On-Call Stipend

1. All care providers who practice in rural communities (mixed model service and under) should be paid for primary care maternity on call work.
2. This stipend would apply to physician call groups in mixed model communities (obstetrician supported by GP Surgeon or GP Obstetrician), communities with GP Surgeon- or GP Obstetrician-led call groups, and communities with call groups of primary care providers (there are 35 such communities in British Columbia; see Map on next page).
3. This recommendation would be strengthened by an on-call stipend for maternity care nurses.

Start-up Stipend for Rural Midwives

1. All midwives who commit to set up a practice in a rural community should receive a start-up stipend.
2. Additional funding may be required for travel due to the geographic realities of providing home based care in rural catchments.
3. Funding must be made available for locum coverage in rural communities to increase sustainability of permanent care providers.

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Rural Primary Care Maternity On-Call Stipend

Formula

The Rural Primary Care Maternity On-Call Stipend is based on current Medical On-Call Availability Program (MOCAP) payment levels, with the assumption that the 35 eligible rural BC communities provide Level 1 MO-CAP on-call services. Care providers will receive only one stream of funding per on-call shift (i.e. A physician on-call for maternity care may not also receive MOCAP payments for her Emergency or Anesthesia call groups during that shift).

Anticipated Implications

- The introduction of on call payment for rural primary care maternity coverage will have a profound effect on the retention, recruitment, and repatriation of rural maternity care providers.
- This stipend will lead to more sustainable practice for rural maternity care providers and the sustainability of regional care centres.
- This stipend will enable women to access intrapartum services closer to home.
- The improved sustainability of rural physician maternity care underpins sustainable rural midwifery care, and is necessary as we work towards integrating midwives into rural communities

Total Provincial Stipend Budget

$$\$225,000^1 \times 35^2 = \$7,875,000$$



Annual Stipend per Physician

$$\$225,000 / 3^3 = \$75,000$$

Note

1. Level 1 MOCAP annual call group payment
2. # of communities that provide maternity care without a full specialist service
3. Typical # of providers within rural maternity call group

Rural Communities Needing
On-Call Remuneration for
Primary Care Maternity Services



Start-up Stipend for Rural Midwives

Formula

- Rural midwifery practice = 40 births/year (3.3 births/month)
- Billing paid per trimester = \$225 each for first, second, and third trimester
- Labour/delivery (L&D) fee and Postpartum fee = \$950 each

Anticipated Implications





- The introduction of start-up funding for rural midwives will increase the feasibility of midwifery practice in communities that have never had midwifery care.
- Travel subsidies will contribute to the fair remuneration of midwife travel in dispersed rural catchments, enabling them to do outreach to women whose communities are under-served due to hospital closure.
- Funding support for rural midwifery locums will increase the sustainability of rural midwifery practice due to providing time off call and away from the community.

Proposed start-up stipend for rural midwives

	Month											
# Clients	1	2	3	4	5	6	7	8	9	10	11	12
4		900			900			5800	4000			
8			900			900			5800	4000		
12				900			900			5800	4000	
16					900			900			5800	4000
20						900			900			5800
24							900			900		
28								900			900	
32									900			900
36										900		
40											900	
44												900
Service billing	0	900	900	900	1800	1800	1800	7600	11600	11600	11600	11600
Start-up stipend	3000	2100	2100	2100	1200	1200	1200	0	0	0	0	0

Total anticipated stipend = \$12,900

Fee per client

-  First trimester ~\$225
-  Second trimester ~\$225
-  Third trimester + birth ~\$1450
-  Postpartum ~\$1000

- Income of \$3000 per month (approx. one course of care) from combination of start-up stipend and practice fees over first 7 months until client volume increases and practice becomes financially lucrative.
- Model based on focus group consultation with rural midwives in British Columbia. The focus group emphasized that this calculation should be considered the minimum for a start-up stipend.
- Model based on no clients coming into care late in pregnancy when midwifery becomes available in the community.
- Model based on approximate 2008 billing fees.

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