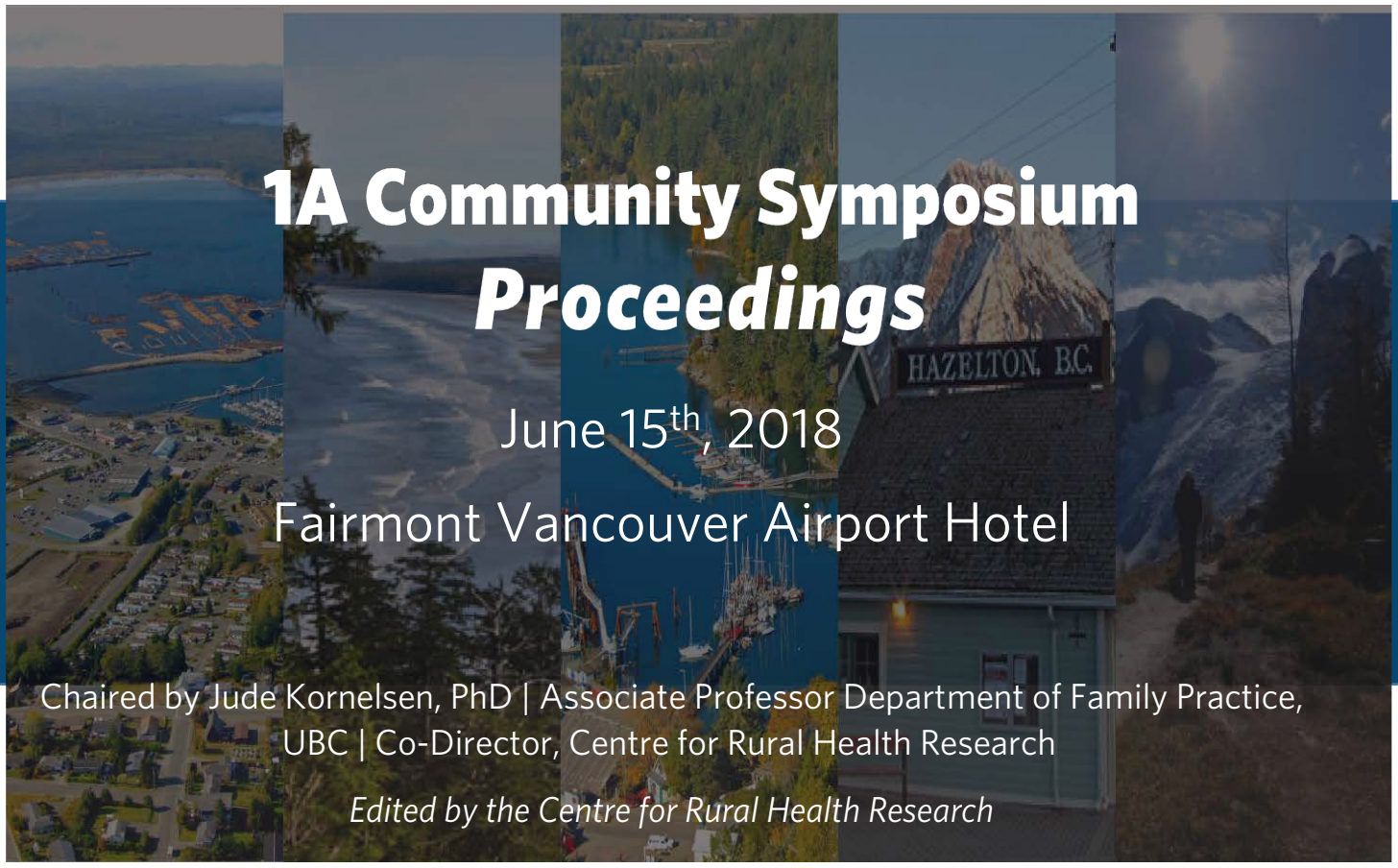


1A Community Symposium *Proceedings*

June 15th, 2018

Fairmont Vancouver Airport Hotel

Chaired by Jude Kornelsen, PhD | Associate Professor Department of Family Practice, UBC | Co-Director, Centre for Rural Health Research

Edited by the Centre for Rural Health Research

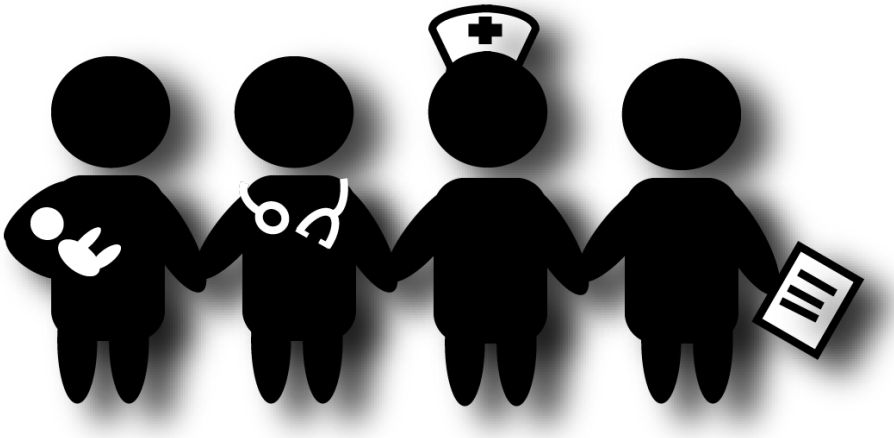


Table of Contents

Executive Summary

On June 15th 2018, physicians, midwives, nurses and site administrators from all five BC communities that offer maternity care without local access to caesarean section (1A sites) met in Richmond, BC, for a consensus symposium. The objective of the invitational meeting was to identify and prioritize common system supports needed to sustain rural maternity services in communities without local access to caesarean section. Nurses, physicians, midwives and health care administrators from all five 1A sites spent the day identifying the system supports needed to support sustainable rural maternity care across the province and coming to agreement on the recommendations to support the common system level interventions. Participants committed to a consensus process: that is, findings and policy recommendations reflect the prioritization of all 1A communities in BC.

Outputs

Challenges to sustainable practice were identified by professional group and included the following:

- Low nursing confidence for nurses due to low procedural volume and the lack of initial education and training, the need for health authority support and the need for reliable transport;
- Physicians identified the impact of low nursing confidence on team practice and readiness for local delivery and the concomitant lack of support for their practice and reinforced the need for supportive relationships with specialists in the regional referral centres. They emphasized the need for timely and reliable patient transport, particularly for precipitous high-risk deliveries;
- Midwives noted the lack of sustainability in the current funding model for low-volume sites, which currently leads to lack of time off call and burnout, and the subsequent need for a salaried or guaranteed income model;
- The necessity of inter-professional collaboration was common across all professional groups, as was the need for improved access to maternal transport in labor;
- Administrators identified a serious lack of support from their regional health authority.

Current Needs

Policy

- *Need for the Ministry of Health and Health Authorities to support rural maternity services (through resources and in principle)*
- *Importance of including rural voices at policy tables*

Compensation for midwifery

- *Salaried model*
- *Funding for recruitment, retention and education*
- *Increased funding for rural midwifery locums*
- *Expanded scope of practice for midwives and accompanying billing codes*

Transport

- *Design and implement transport protocols that address local needs within larger system constraints, this includes valuing and including the expertise of local care providers in transport decisions*

Data

- *Developing a robust evaluation and quality improvement framework for continuous outcomes monitoring – analysis must be responsive and enable service change where required*

Education

- *Increased nursing education including out-of-community experience*
- *Relevant ongoing clinical practicums and practical experience for nurses*
- *Work with nursing education key-stakeholders to ensure maternity skills at graduation*
- *Increased CME funding for both midwives and nurses*

Networks

- *Build lateral networks for rural/remote/low-volume sites to support one another*
- *Building networks between rural low-volume communities and specialists in regional referral centers; foster working relationships to support iterant specialist care in referral communities*

Inter-professional models of care

- *Collaborative care model and associated payment structure and buy-in from physician community*

Recommendations

1. That the BC Ministry of Health (MoH) and Regional Health Authorities (RHA) responsible for 1A sites issue a clear statement of system support for rural maternity care without local access to caesarean section.
2. That the Midwives Association of BC (MABC), MoH, RHAs, General Practice Services Committee (GPSC) and Shared Care work together to create strong inter-professional rural maternity care teams.
3. That MABC and MoH agree to discuss alternative models of funding to adequately support midwives in low-volume communities, including locum coverage.
4. That the Association of Registered Nurses of BC work with the MoH and RHAs to achieve compensation for: a) ongoing training and education for rural maternity care; b) paid exposure to high volume sites; and c) where appropriate, funding for additional nurses to attend labour and delivery in an educational capacity. That the GPSC, MoH, MABC and RHAs work to recognize midwives as key players in Primary Care Networks.

Next steps

On October 12th, the Centre for Rural Health Research will host an invitational meeting for Ministry, Health Authority and Professional Association representatives to respond to the outputs from the June 15th symposium. We anticipate collaboratively developing timelines for key decision points and an action plan that reflects the urgency of community sustainability.

Preface

The attrition of rural maternity services without local access to cesarean section in BC and elsewhere that has occurred in the past two decades has been well documented, as have the health, social and cultural consequences. The fact that this is occurring within a policy context that increasingly values and prioritizes the cultural move towards primary care as a way to meet the objectives of the quadruple aim, however, has not stemmed the tide of closures, nor has the historical policy precedent of care 'closer to home'. Not even the support of the relevant specialist organization, the *Society of Obstetricians and Gynecologists of Canada*, through policy statements urging respect for local maternity services in rural settings and the ensuing support for a woman's right to choose location of birth has seemed to refocus system attention on the problem. This refocusing, however, is essential if these small services are to thrive (beyond wavering on the line of sustainability). There does not seem to be any clear desire to close the services, *we have just not paid enough attention to them*. The omission of intention, however, has left rural maternity care providers left with trying to fulfil their mandate to meet the needs of the populations they serve without appropriate supports.

The 1A Community Symposium was held in Richmond BC on June 15th with funding from the Joint Standing Committee on Rural Issues through the Rural Coordination Centre of BC and brought together nurses, physicians, midwives and site administrators from all of the 1A communities in the province. This in and of itself is significant as, for the first time, care providers and administrators from diverse communities were able to network, share what is working and identify common, systemic problems that challenge sustainability. The community-focused day provided an opportunity to document and ratify what is needed from a rural provider and administrator perspective and thereby provide a framework that can be used to reinforce these services. This work builds on the growing literature on both rural women's experiences of and desire for maternity care and the BC, Canadian and international literature on the safety of such services. It also aligns with Canada's *Truth and Reconciliation Commission* findings which provide a context for understanding Indigenous reclaiming of local birth as part of the reconciliation process.

Although the focus on June 15th was on care providers' experiences, strategically chosen as a way to bridge the gap in understanding of rural maternity care providers needs, the yields from the day are one part of a larger discussion that has involved birthing women, Indigenous communities, Health Authorities and the Provincial Ministry of Health, policy and decision makers and researchers. What we learnt on June 15th will be part of this larger, essential, ongoing discussion and we plan to meet with other key stakeholders in the fall to continue the discussion. We also need to develop and implement a framework for Quality Improvement and evaluation for the 1A sites so we are clear on the safety of low resource deliveries in the BC context and understand the cost projections of both supporting the services *and of closing them.*

There is growing attention in British Columbia on sustaining low volume surgical services through the Joint Standing Committee on Rural Issues' funded Rural Surgical and Obstetrical Networks (RSON) program. This initiative finds it roots in the need to sustain rural maternity services and the concomitant recognition that sustainability is difficult without local access to surgical delivery, if the population is big enough to warrant such services. The RSON framework provides a funding envelope to reinforce rural surgical programs at risk of closer due to low procedural volume and is the product of innovative and courageous thinking and political actioning. We must pay careful attention, however,

that the just-in-time and necessary focus on surgical services does not overshadow communities that, due to procedural volume and isolation (or proximity), will not be likely candidates for local surgical services, but have enough volume to support local low-risk deliveries. Many of the same structural supports underscoring RSON – clinical coaching with regional centres, increased scope and volume, developing rigorous mechanisms for Continuous Quality Improvement and implementing a strong evaluation framework – can be applied to networks including communities without local access to cesarean section. We must also recognize the distinct challenges unique to the low-resource sites as detailed in this document.

We need action now. Four of the five services report significant instability due to an array of issues discussed in this report, so timely action is essential. History has shown us how difficult it is to re-open services once they close. **At a provincial level, we need endorsement that in alignment with provincial health policy, respecting the community-based directives of the First Nations Health Authority, with assumptions of safe care and the availability of system resources, 1A sites are supported by the Ministry of Health. At a Health Authority level, we need commitment to a process to determine appropriate location of rural maternity services based on established and validated metrics, and a further commitment to work with local community members, care providers and administrators to build up these services in a way that respects fiscal and other planning responsibilities in balance with community need.**

Some of the system-level implications of these endorsements are found through the 'building blocks' to sustainable care that those at the June 15th meeting identified and are presented in this report. Other implications will be determined through provincial and regional processes. The composite impact, as far as it is understood, must be considered when making decisions regarding whether or not to actively support 1A maternity services in BC. As the evidence demonstrates, however, closing them is not a viable option if we are to maintain our provincial commitment to optimal health outcomes. This consensus statement provides a framework for considering the supports that are so urgently needed.

Jude Kornelsen, PhD
Co-Director, Centre for Rural Health Research

Introduction

A gap currently exists between system imperatives of birth 'closer to home' and health service supports that enable such care in rural, low-resource communities. In British Columbia, there are only five rural communities with low-resource maternity services (no cesarean -section backup), including Invermere, Hazelton, Salt Spring Island, Port McNeill and Haida Gwaii. Each of these five communities provide maternity services with a model of care unique to their rural context and with varying degrees of inter-professional (physician and midwife) collaboration.

In 2016, the Centre for Rural Heath Research (CRHR) received funding from the Joint Standing Committee on Rural Issues to look at the 'building blocks' to sustainable rural maternity care for the North of Vancouver Island, specifically what it would take to sustain the 1A (no local cesarean section) service in Port McNeill. Through this community- and care provider-driven process, we established five key system needs to support local maternity care. These include (1) mechanisms for increasing confidence of providers (with an emphasis on nurses) in a low volume setting; (2) efficient access to emergency transport; (3) evidence-based inclusion criteria for local delivery; (4) linkages with regional referral specialists and (5) inter-professional models of care involving midwives. These core building blocks are underscored by the need for a commitment of support from the Ministry of Health and relevant Health Authorities.

As part of the North Island project, our team had ad-hoc conversations with key stakeholders from the other 1A communities in BC (Haida Gwaii, Salt Spring Island, Hazelton and Invermere). Consistent in these discussions was the desire to learn about and understand other models of maternity care in 1A communities across the province including successes and challenges. To this end, we secured funding from the Joint Standing Committee on Rural Issues through the Rural Coordination Center of BC for a one-day symposium to bring together providers from the 1A communities.

The symposium was held Friday June 15th, 2018 in Richmond, BC. We invited four participants from each community: the local hospital administrator, a physician lead, a midwife practicing in the community (where applicable) and a maternity care nurse. To increase efficiency on June 15th, we held one-hour teleconference calls with each community's maternity care team prior to the meeting to survey the particulars of the care model and challenges and collate what we heard to provide it as a starting point for discussion.

Objectives

1) To identify and consolidate the system supports needed (using the 'building block' framework) across all sites, to support sustainable rural maternity care (non-cesarean-section services) in the five participating communities

2) To seek agreement on the recommendations to support the common system level interventions that will inform a proposal (written/presented) to Ministry of Health and Regional Health Authority, professional bodies and key-stakeholders

Background

Building Blocks to Sustainable Rural Maternity Care: The North Island Project

The First Nations Health Authority received funding from the Joint Standing Committee on Rural Issues in March 2017 to develop a decision aid for choice in place of birth for rural women from low resource (no cesarean section) communities. We heard concerns regarding the sustainability of local services in initial community consultations so proposed to instead do a feasibility analysis of sustainable maternity care on the North Island.

In 2015-2016, 7 deliveries occurred in the Port McNeill hospital out of approximately 110 pregnancies in the population catchment (PSBC data). In comparison, 12 deliveries occurred in Port Hardy hospital, a community that does not offer planned local deliveries. Although research evidence does not attribute a correlation between procedural volume and outcomes in maternity care, there is a known correlation between low volume and provider sustainability. The current procedural volume in Port McNeill is not sustainable, due primarily to the lack of practice opportunities afforded to (primarily) nurses.

Five 'building blocks' to sustain rural maternity care in the North Island emerged from in-depth community- and provider-consultation (Figure 1). Overarching principles emphasize the importance of simultaneous development of all five building blocks, of a community-driven process and the necessity of system support.

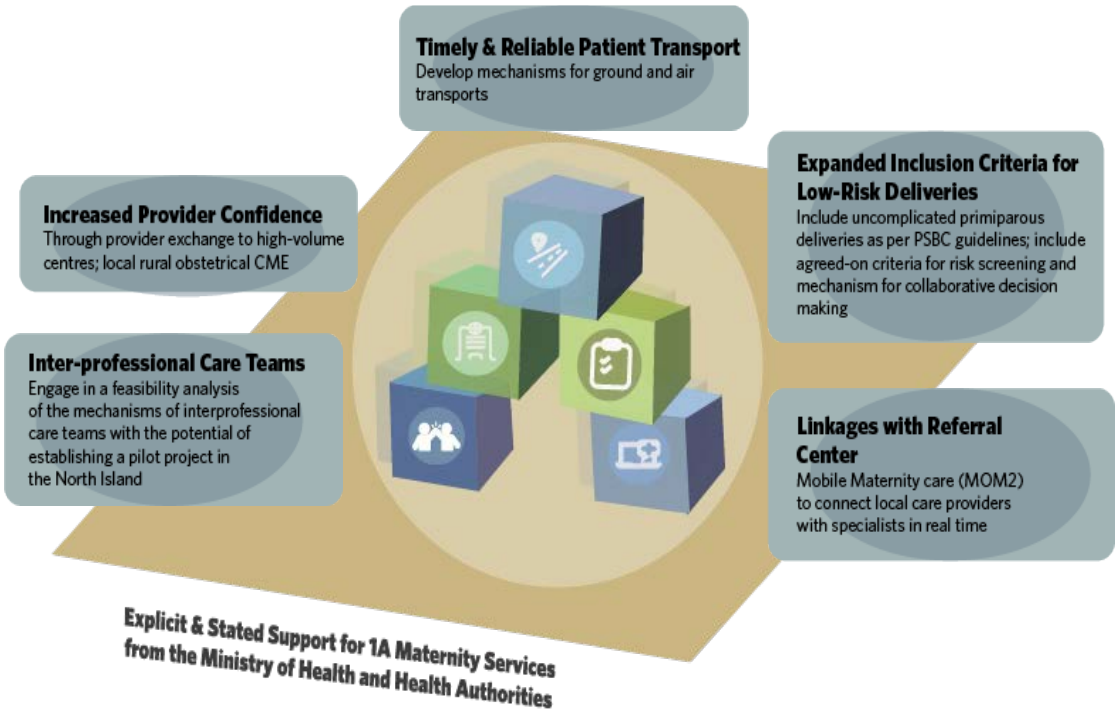
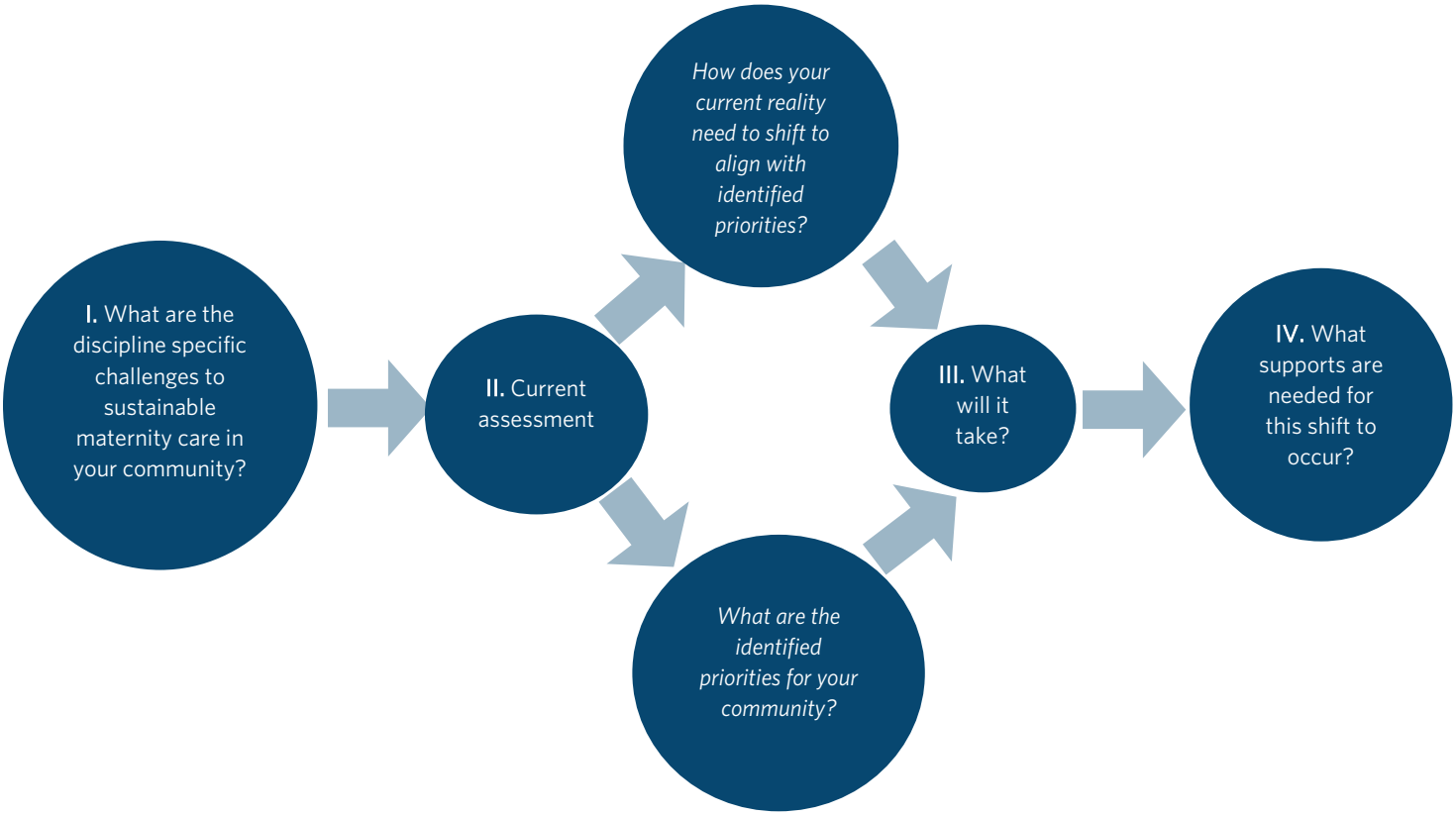


Figure 1. North Island 'building blocks' to sustain local maternity care

Approach

The symposium was community-focused and remained committed to hearing from the 1A local care providers directly. The day was organized to achieve a flow starting in the morning developing the context of each care provider group and the unique context of each 1A community. We then moved into understanding common challenges, followed by asking 'what will it take?' and 'what is required for this change to occur?'



What We Heard

Throughout the day, we engaged maternity care providers from the five rural communities to discuss and brainstorm solutions to sustain their maternity services. The discussion summaries are found below.

I. What are the discipline specific challenges to sustainable maternity care in your community?

Attendees sat according to professional group. Table discussion questions included: As a (physician/midwife/nurse/administrator), what are your challenges to sustainable maternity care? What has worked well in your community? From your professional vantage point, what would you like to see in your community? What are you concerned about in your community? In your profession, what is the most important issue/challenge to be solved in order to have sustainable maternity care?

Site Administrators

Low nursing confidence

- It is difficult to find nurses who are comfortable and competent to deliver.
- Administrators require more staff or locums so that other employees can leave for training.
- Administrators would like to have enough funding to have an on call maternity nurse.

Need support from Health Authority

- **Serious lack of Health Authority support.** Is it better to operate 'under the radar' to avoid further restrictions on local services or to ask for support?

Need for reliable transport

- Many transportation issues. Need better transportation system for faster and more efficient transport.

Physicians

Low nursing confidence

- Nurses are not comfortable and confident with obstetrics because there is not enough volume for them to observe and practice deliveries.
- Physicians feel overwhelmed to deliver due to lack of staff support in maternity care. Many felt it difficult to maintain a continued practice due to competing priorities (ER call, outreach work, etc.).
- Discussion around being more selective in who communities hire (i.e. only hire physicians who are interested in maternity care) so they can increase inter-professional work.
- Some maternity staff (nursing) reported losing confidence due to the MOREOB program as the scenarios were not rurally-suited. Others said MOREOB worked well, with modifications, in their community.

Midwifery funding challenges

- It needs to be a high priority for Health Authorities and the Ministry of Health to determine who is responsible for an alternative payment for midwives.
- Physicians in two communities are individually subsidizing midwives' overhead because the midwives are not sustainable based on billable volume.

Necessity of inter-professional collaboration

- Clear communication among the maternity care provider team is important. There seems to be a lack of trust between physicians and midwives in some communities (where physicians are unsure of a midwife's ability to do certain tasks) which creates distance and isolation in the workplace. Important to set up meeting with each other to discuss their knowledge and skills to understand and help each other work as a stronger team.
- Need collaboration of the General Practices Service Committee to integrate midwives into the Primary Care Home.

Necessity of reliable transport

- Transportation out of small communities is difficult in many jurisdictions, which enhances the necessity of local maternity care.

Need for referral centre support

- Physicians need to feel supported by their referral centres.

Midwifery funding model challenges

- Appropriate funding model (including the rural locum program, time off, on call coverage, appropriate salaried funding, transport back to community) and increased hospital privileging for midwives (locum and/or an additional MW in the community/timely access).
- Payment and time off to prevent burnout.
- Compensation for being on call 24/7.
- Some of the communities need to go on diversion if the midwife leaves the community, thus giving rise to extended time on call.

Referral centre support

- Desire for mentorship and inter-professional learning with referral site. This would support communication and understanding to flows both ways (referral centre understands rural working environment and reciprocally).

Need for reliable transport

- Need better response for transportation.

Need for inter-professional care teams

- More support needed from other staff for tasks such as doing charts, clinic lab, etc.
- If a midwife loses someone in her nursing compliment, practice becomes unsustainable because there may not be anyone to fill in.

Perceived lack of Health Authority support led to:

- Doing things 'under the radar' to survive and to continue providing services.
- Feeling unsupported by the Health Authority/that their privileges can be taken away, so 'we remain silent'.
- Considerable fear that the Health Authorities will shut down services.
- Hospital/Health Authority need to include midwives as autonomous primary care providers in discussions and decisions to increase the visibility of the profession.
- The need for further **integration** into the health system, including paid positions where appropriate.

Low nursing confidence

- Lack of confidence in ability to deliver; a lot of anxiety.

Need for reliable transport

- Transportation is a huge issue. Takes a long time and the transport teams are split without the right equipment so paramedics may be unable to keep moms and babes together.

Inter-professional model

- Need for a nursing mentorship model that is midwifery-led with nurses on call and compensated appropriately.

Need support from referral centres

- Delivering in the middle of the night in their communities is difficult – nurses need more support.

Need for continuing education/training to maintain skillsets

- Frequent training and reinforcement of skills is necessary (i.e. CPD programs every 1-2 years).

II. Assessment of Current Resources and Challenges

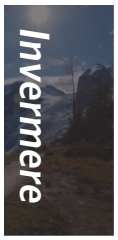
Attendees seated by community. Discussion questions included: What are the identified priorities ('building blocks') for your community? How does your current reality need to shift to align with identified priorities ('building blocks')? Summary of discussion is included below.

- Continuing education for midwives
- Funding for nursing education
- Linkages to regional referral sites ('good working relationship with referral site so you know each other and each end has understanding of each other's context')
- Public context and awareness around rural maternity
- Creative solutions for transport - i.e. sending a physician, or ALS crew for maternal transport
- Specific funding/protected budget line for maternity
- Venue for communities to create local policy
- Have space for conversations around sustainability with providers working in similar contexts (inter-disciplinary; lateral networks) – a forum similar to SRPC (but inter-professional not just for physicians)

- Need a midwife integrated into the local maternity care practice
- Need access to electronic medical records in hospital for antenatal care

- Alternate funding model for midwives (with involvement from GPs)
- Surgical program, if possible, with elective c/s
- Education for nurses (on normal birth) including simulations of 'normal birth'
- Transport problems resolved – consider bringing specialist services to patients; PTN is not helpful

- Establishing an alternate payment model for midwives to enable their continued work as well as some back up
- Funding for nursing education (comfort in hospital and home delivery)
- Streamlining PTN process – there may be times where it is better to bring specialists to the patient



- Education - provided by midwives to nurses so nurses won't need to leave the community to get training. Support nurses to spend times with [midwife] and be exposed to pre-natal and post-natal care (with funding provided).
- Add 'resiliency' (as a building block) "who is going to take care of the care providers?"

Strategy Showcase

Invermere ~ Inter-professional care model

Kyra Warren (Invermere) discussed their inter-professional model of maternity care.

Hazelton ~ Client evaluation process

Angela Smith (Hazelton) presented on her client evaluation process.

Salt Spring ~ Struggle to sustain

Erin (Salt Spring Island) discussed the struggles to sustain maternity care on Salt Spring as a solo midwife including problems with remuneration, feeling invisible within the system, inability to take time off and the need for system changes to support rural/remote midwifery.

Haida Gwaii ~ Maternity nursing skills

Celina Larson (Haida Gwaii) presented on their maternity nursing skills training through the creation of a two-day nursing course.

III. What will it take? *Actions supporting change and addressing challenges*

Attendees were seated by community and asked to identify action 'interventions' (health system supports from local to provincial/national level) needed to occur to support each of the previously identified areas. Summary of discussion is included below.

Table discussion summary

- Interest in employee benefits such as pension and disability insurance for midwives.
- Midwives stated that autonomous practice is very important and that signing a contract (such as what some of the GPs have done for an alternative payment program) would be desirable.
- Incorporating midwives into medical staff meetings and rounds could be beneficial in some communities that are not already doing so.
- Some midwives discussed the importance of feeling supported by their physician colleagues (i.e. back up for emergencies, ability to refer to them).
- Groups spoke about the need for education for nurses around birth and the possibility of having the midwife in the community provide this education (with compensation). This would address the need for education relevant to the community context and play a part in increasing compensation

for the midwives. This could be accomplished through team education sessions or one-on-one mentoring.

- Importance of incorporating midwives into Primary Care Networks (PCN)/homes. Ideally this could be run as a proof of concept study around the 1A sites incorporating midwives into the PCN, as midwives are already doing this without the recognition (for example, some communities have physicians and the midwife sharing call time or physicians covering midwives when needed).
- Need for increased billing for fee for service may be important and this could include different rates for different communities, incorporating in the costs related to travelling to communities to see a patient.
- There is a lot of interest in the current 1A sites being 'Proof of Concept' communities showcasing Primary Care Networks that include maternity and midwifery.
- Discussion around making MoreOB more applicable for all rural sites, taking notes from the sites that have adapted it to work well within their own context.
- The idea that community care should include care from beginning of life to the end of life was discussed, with a note that much of the care in the communities currently focuses on end of life care. Without local birth the continuum of care in incomplete for the community.
- Need stated and written support that the Ministry of Health and Health Authorities support the 1A maternity sites.
- Discussion surrounding expanded scope of practice for midwifery with accompanying billing guides as a means to added income to sustain rural midwives.

'Post-it' note board

Each table group wrote post-it notes to add to a larger group board entitled "Actions to Support Rural Maternity Care". Groups were asked to share proposed action items and discuss them as a larger group. Through this process, seven categories arose organically and through consensus.

Compensation for Midwifery	Education	Inter-professional models of care	Policy	Networks	Transportation	Data
Financial support for maintaining maternity care locally	Increased education and funding for training and maintaining nurse competencies in maternity care – ideally on site	Collaborative care model – payment for this model by the Health Authorities	Need for the Ministry of Health and Health Authorities to support rural maternity services (through resources and in principal)	Build lateral networks for rural/remote/ low-volume sites to support one another	Need emergency transport services to be more responsive to local needs	Importance of collecting data to define the number of practitioners needed to run maternity service
Need for designated money set aside to support labor and delivery sites, recruitment and retention of maternity care providers, education that is specific and relevant to the level of care offered in community	Relevant ongoing clinical practicums and practical experience for nurses	Include midwifery office within physician clinics or hospital (cost covered to decrease midwives' overhead)	Importance of including rural voices at policy tables	Need for networking with OBGYN specialists to influence, participate and add to the dialogue – building stronger interdisciplinary networks to increase communication	Use of travelling surgical teams if mother cannot leave community safely	
Compensation for midwives that is more similar to rural physician compensation (provides maternity care incentives, locum reimbursement, CME funding)	Discuss the education requirements for graduating nurses at the university level	Need for physician support for maternity programs and willingness to be helpful in emergencies (physicians locally and from referral centres)	Direct connection of policies to protocols			
Need for improved funding model for midwives that may include a salaried position (alternative payment program)	Exchange programs for nurses to train in higher volume communities that provide relevant experience (i.e. mentoring with a midwife	Inclusion of midwives with expanded scope into the model of care and use of the midwives as local educators (funded)				
Compensation in place for midwifery locums for midwives to take time off without losing money – stabilizing and expanding the rural locum fund for midwives and	Increased CME funding for both midwives and nurses	Fostering and developing working relationships with travelling surgical teams who could bring care to the patient				

addressing locums for remote sites						
Increasing/defining expanded scope of midwives with accompanying billing guides that allow them to work under alternative funding models – Well Women and baby care, IUDs, vaccinations	Focus on education for nurses that is relevant to working in a 1A site					

IV. What supports are needed for this shift to occur?

Attendees were seated by community. Attendees were asked to prioritize 'asks' in order of passion, cost and impact. Summary of discussion is included below.

General participant discussion

- Acknowledgement that consumers and costs are major driving forces behind change and that when the message is coming from "us" (providers) it is not heard as strongly as when it comes from the women themselves.
- There is a need to show that a) the services will save money and b) that the consumers want the service.
- Acknowledgement that we cannot simply "buff up" midwifery salaries without addressing systems that (currently) do not support them.
- Need 'proof of concept' program to demonstrate the efficacy of local services.
- Discussion around wanting to avoid a "turf war" between urban and rural midwives and rural midwives and physicians.
- Need to engage with educational bodies (universities) to discuss the need for graduating nurses who are 'job ready' for rural settings.
- Need funding for midwives that is commensurate with rural funding (i.e. Maternity Care of BC incentives).

Attendees were then asked to assign the appropriate governing body to each 'ask' i.e. Ministry of Health; professional bodies; Health Authorities; local administrators; referral centers; other key-stakeholders.

'Ask'	Identified target for 'ask'
Need for rural maternity care to be discussed and negotiated in the context of a coherent interdisciplinary team of care providers.	*Ministry of Health*
Need Midwives Association of BC to create a new table on funding rural midwives that will look into alternative payment models and collaboration with current systems that support rural maternity care.	*Ministry of Health; Midwives Association of BC*
Need to discuss increased scope of practice for midwives and accompanying billing codes.	*Ministry of Health; Midwives Association of BC*
Need to create a collaborative care funding model through the Midwives Association of BC Master Agreement.	*Ministry of Health; Health Authorities; Midwives Association of BC*
Need for adequate locum funding to cover and maintain maternity services and need for a rural midwifery advocate (as a staffed position).	*Ministry of Health; Professional Bodies*
Importance of working out privileging for midwives with the Health Authorities.	*Regional Medical Directors; Health Authorities*
Need a commitment to more funding for rural maternity sites.	*Health Authorities*
Need support for the integration of midwives into Primary Care Networks.	*Ministry of Health; Health Authorities*
Need reciprocal mentorship for registered nurses at high volume sites to maintain competency through mentorship with registered midwives/registered nurses.	*Health Authorities*

Recommendations

1. That the BC Ministry of Health (MoH) and Regional Health Authorities (RHA) responsible for 1A sites issue a clear statement of system support for rural maternity care without local access to caesarean section.

2. That the Midwives Association of BC (MABC), MoH, RHAs, General Practice Services Committee (GPSC) and Shared Care work together to create strong inter-professional rural maternity care teams.

3. That MABC and MoH agree to discuss alternative models of funding to adequately support midwives in low-volume communities, including locum coverage.

4. That the Association of Registered Nurses of BC work with the MoH and RHAs to achieve compensation for: a) ongoing training and education for rural maternity care; b) paid exposure to high volume sites; and c) where appropriate, funding for additional nurses to attend labour and delivery in an educational capacity.

5. That the GPSC, MoH, MABC and RHAs work to recognize midwives as key players in Primary Care Networks.

Other important considerations

- Create clear timeline of when changes for identified priorities will take place.
- Input from all professional bodies required to make well-informed decisions of what the communities need to be sustainable.
- Care providers and public to take action and spread awareness through addressing letters to the government and other decision makers.

Closing remarks

Michael Sandler, Association of Registered Nurses of BC Rural and Remote Policy Table

- *Why do we do this (rural)?*
  - We love our team
  - We love where we go to work each day
  - We love the impact we get to make

- *Issues we face:*
  - We all work at the edge of our scope. A solution to that? We optimize our scope so that it fits our practice.
  - We need to speak up. Our rural and remote reality is very different from urban. We need to be vocal about this.
  - Health human resource challenges.
  - Take the opportunity from the rural and remote lens to inform the conversation - we are the users. Take our experience to mold a system that works for us.

Kim Williams, Networks Director, Rural Coordination Centre of BC

- We want to link into the work we (as a larger organization/system) are doing (i.e. Primary Care Networks with maternity care) to the work these 1A communities are doing
- Importance of keeping the inter-disciplinary piece
- Looking at communities, and their relationship with 'partner communities' or referral communities
- Pentagram partners is something to be thought about in terms of 'hexagon' partners (possibility of involving industry partners in some communities)

Glenys Webster, Director Women's, Maternal and Early Childhood Health BC Ministry of Health

- Acknowledgement of the challenges of providing rural maternity care, and appreciation for the work that is being done by care providers.
- Expression of thanks for having been included at today's discussion. Participants' concerns will help guide discussions at MoH as we work to improve rural maternity care.
- The Ministry's focus on gender equity opens a policy window for rural maternity care
- There is a need to determine what data and research are needed
- There is a need to address the disparity between educational funding for physicians and midwives

Hanna Scrivens, Project Manager, Kwakwaka'wakw Maternal, Child and Family Health, First Nations Health Authority

- Acknowledgement of the work all the rural care providers have done
- Birth close to home is an important step towards reconciliation
- Comment around the necessity of these supports (maternity care) in order to attract people and industry into these rural communities

Next Steps

The first step will be to receive feedback from participants regarding the drafted proceedings. After we receive feedback and reach a consensus, the finalized proceedings will be available to be shared with communities, professional bodies, and other key stakeholders.

Additional steps:

- Creation of a policy brief by Dr. Kornelsen incorporating attendee feedback.
- Presentation of the policy brief by Dr. Kornelsen to co-chairs of the Joint Standing Committee on Rural Issues.
- Continued media outreach to ensure community level knowledge translation.
- Application to the Joint Standing Committee on Rural Issues to create a cost-effective evaluation for all 1A sites.
- Work with support from the Association of Registered Nurses of BC to understand the requirements for graduation of rural nurses at an institutional (educational) level and ensure appropriateness to training for rural practice.
- Consideration of how we can raise awareness politically, what tools we can use to engage the community for support, and how to find the "right words" to get our message heard at the government level.

Attendees

Haida Gwaii

Kerry Laidlaw	Administrator	kerry.laidlaw@northernhealth.ca
Celina Laursen	Midwife	celina.laursen@northernhealth.ca
Amy Clarkson	Nurse	amy.clarkson@northernhealth.ca
Caroline Shooner	Physician	caroline.shooner@northernhealth.ca

Hazelton

Maureen Den Toom	Administrator	maureen.dentoom@northernhealth.ca
Angela Smith	Midwife	angela.smith3@me.com
Carmen Wiebe	Midwife	carmentw03@gmail.com
Kia Beertema	Nurse	kia.beertema@northernhealth.ca
Charlie Eckfeldt	Physician	charlie.eckfeldt@northernhealth.ca

Invermere

Deborah Austin	Administrator	deborah.austin@interiorhealth.ca
Kyra Warren	Midwife	kyra.warren@gmail.com
Katherine Jerabek	Nurse	katherine.jerabek@interiorhealth.ca

Port McNeill

Angelika Starr	Administrator	angelika.starr@viha.ca
Pamela Moore	Nurse	pam.moore@viha.ca
Gregory Kutney	Physician	gregorykutney@gmail.com
David Whittaker	Physician	pmmc.health@gmail.com

Salt Spring

Sara Gogo	Administrator	sara.gogo@viha.ca
Erin Price	Midwife	erinp24@gmail.com
Kelly-Ann Haslauer	Nurse	kahaslauer@gmail.com
Paula Ryan	Physician	paularyan@shaw.ca

Other attendees

Glenys Webster | *Director Women's, Maternal and Early Childhood Health, BC Ministry of Health*

Michelle Barros Pinheiro | *MD Policy Analyst Women's and Maternal Health, BC Ministry of Health*

Michael Sandler | *Chair of the Rural and Remote Policy Table, Association of Registered Nurses of BC*

Lee Yeates | *Collaborative Practice Development Consultant with the Shared Care Committee & Co-Lead, Rural Obstetrics Network with the Rural Coordination Centre of BC*

Kim Williams | *Network Coordinator, Rural Coordination Centre of BC*

Hannah Scrivens | *Project Manager, Kwakwaka'wakw Maternal, Child and Family Health, First Nations Health Authority*

Attendees and organizers at the 1A Community Symposium at the Fairmont Vancouver Airport

(Missing in photo: Salt Spring Island care providers)

June 15th, 2018

Agenda

Time	Item	Lead
7:30am	*Breakfast*	
8:30am	*Welcome*	
	• Welcome remarks • Opening Prayer/Reconciliation acknowledgement • Introductions	Jude Kornelsen
9:00am	*Context setting* • Share background of *Building Blocks to Sustainable Rural Maternity Care* project • To share information gathered from interviews • To engage participants for feedback • To respond to any questions for clarity	Jude Kornelsen
9:45am	*What are the building blocks for your profession?*	Table Activity (Sit by health profession)
10:30am	*Health Break* *-participants move to their 'community' tables*	
10:45am	*Current assessment* • How does our current reality need to be adjusted to align with identified priorities ('building blocks')	Table Activity (Sit by community)
11:45am	*Group reflection* • Critical insights about system changes needed to support 'building blocks'	Group Discussion
12:15pm	*Lunch and strategy showcase* • Invermere (inter-professional model) • Hazelton (client evaluation process) • Salt Spring (struggle to sustain) • Haida Gwaii (maternity nursing skills)	Kyra Warren Angela Smith Erin Price Kerry Laidlaw & Celina Laursen
1:30pm	*What it will take: actions supporting change and addressing challenges*	Table Activity (Sit by community)
2:10pm	*Group reflection* • To share proposed ideas • To assess themes and strategies that are emerging • To identify gaps in supports	Group discussion
2:30pm	*Health Break*	
2:45pm	*Who do we need to help us?* • To identify support needed from key stakeholders including professional bodies, Health Authorities, and Ministry of Health	Table Activity (Sit by community)
3:30pm	*Group task* • Assess and prioritize the proposed supports • Discuss process of policy brief development (CRHR) • Consensus (?) • Strategic reporting back (to key stake-holders) • Accountabilities	Group discussion
4:00pm	*Next steps*	Group discussion (Jude Kornelsen facilitates)
	Closing Remarks	Michael Sandler Kim Williams Glenys Webster Hanna Scrivens
4:30pm	*Event Close*	Jude Kornelsen