Rural 1A Maternity Sites in BC Symposium Proceedings

Working Together for Sustainability

October 29th, 2018
Victoria, BC

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

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Preface

There is a growing recognition of the consequences – both intended and unintended – of the closure to rural maternity services in British Columbia and attendant key-stakeholder interest in addressing the growing health service delivery gap. There is also a tacit understanding of the enormity of the task. The service levels that have been and still are the most vulnerable to the vagaries of larger health system trends – for example, challenges recruiting and retaining health care providers and inter-professional barriers to practice – are the 1A sites: those without local access to caesarean section. The very characteristics that define these sites – low population density leading to low procedural volume – demand solutions separate and distinct from system interventions geared for more broad application. Small rural is different.

Since 2004, the Centre for Rural Health Research has focused on creating an evidence base on the context and enablers needed to support 1A maternity services. This has been done through primary research, research synthesis of best practice models internationally and deliberative dialogue through meetings and symposia with key stakeholder groups. The yield of these activities is a solid evidence-base that is consistent with international opinion and incorporates locally-developed solutions to address the health services delivery needs in British Columbia. A symposium on June 15th brought together physicians, nurses, midwives and administrators from all of the 1A sites to prioritize the evidence-based system interventions they needed to remain sustainable.

Sustainability, however, demands expressed desirability to support these services by all key stakeholders from the Ministry of Health, to Health Authorities and professional associations. This is aligned with our national obstetrical body (SOGC), the calls to action of the Truth and Reconciliation Commission and the overwhelming evidence on safety and efficacy. The implications of such a statement are well-understood from legal, political, financial and operational perspectives. They are also recognized as *key enablers of moving the discussion forward* and can be supported by the '1A blueprint' that was developed through consensus in June. The key recommendations include:

- Fostering and supporting an inter-professional commitment to creating strong, inter-professional rural maternity care teams based on the *equity of all players*;
- The negotiation of alternative funding models for midwives practicing in 1A settings that honour the comprehensive care they provide throughout the childbearing year. This requires attention to the vagaries of their rural location and the additional supports needed to stabilize practice (i.e., on-call funding and on-call relief, CDP funding, financial support to accompany clients to referral centres if needed). *Rural midwives must be the architects of this agreement;*
- Attention to and support for the needs of rural generalist nurses who are required to work to the edges of their training in many domains and are often asked to do so in maternity care without the necessary base training, continued education or clinical supports (see 'Building Blocks to Rural Maternity Care' for a description of just-in-time initiatives to achieve nursing competence);
- To work in concert with the provincial Patient Medical Home/Primary Care Network strategy to include planning for maternity care as part of the service plan requirements.

This is our blueprint for achieving what we all aspire to: sustainable, culturally respectful maternity care as close to home as is feasibly possible. The institutional constraints on moving this agenda forward are significant and, at times, slower than we all would like. It is our hope that 'Working Together for Sustainability' symposium catalyzed some of the relationships that will be necessary for undertaking the task of stabilizing care for women and families in rural communities across BC.

Background

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. Maternity care providers and health care administrators from Hazelton, Haida Gwaii, Port McNeill, Invermere and Salt Spring 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.

Working Together for Sustainability symposium was a follow up invitational meeting for Ministry of Health, Health Authority and Professional Association representatives to respond to the outputs from the June 15th symposium. This meeting was hosted with hopes of collaboratively developing timelines for key decision points and an action plan that reflects the urgent need for interventions to support community sustainability.

Objectives

The objectives for the meeting were three-fold:

1. To honor and acknowledge the work of key stakeholders who are involved in supporting rural maternity care;
2. To facilitate opportunities for collaboration between Ministry of Health, Health Authority, Professional Association and other key-stakeholder representatives regarding actions to support sustainable rural maternity care; and
3. To discuss outcomes from the June 15th community-based symposium on community-level provider needs to sustain rural maternity services.

Importance of Local Birth

Jessica McLaughlin, mother of two, and long-time North Vancouver Island resident, shared her and her community's experiences of birth. Jessica emphasized the importance having the choice to deliver locally. Jessica travelled 'down island' (~2 hours drive time) to access midwifery services for both of her pregnancies as there is no midwifery care on the North Island. Jessica emphasized this is something women in the North Island want. Most North Island women choose birth location by cheapest accommodation options; for others, it is about renting a place that allows homebirth.

Jessica admitted her longing for control in her pregnancy and delivery, but recognized giving birth is very unpredictable. She found having a midwife as her 'birth secretary' invaluable in the process. Having her midwife with her brought a part of Jessica's 'home' and familiarity with her when she was giving birth. Jessica acknowledged the need for a realistic approach to birth in rural communities, particularly in regards to access to timely and reliable transport.

Research & Policy Context

Jude Kornelsen, Co-director at the Center for Rural Health Research, presented relevant evidence on the safety and necessity of maternity care for rural women. Jude presented the strong policy context in Canada that supports 'birth close to home' for rural women. The following provides a brief overview of what was presented. The references provided can be followed for more information on each.

Evidence on:

- Safety of rural maternity services without local access to cesarean section[1,2,3,4,5,6]
- Adverse outcomes related to distance to services (proportionate) [7,8,9]
- Social disruption caused by relocation[10,11,12,13,14,15]

Policy Context:

- Governmental[16,17,18,19]
- Professional associations[20,21]
- Indigenous imperatives[22,23,24]

Community Mandate:

- Over-arching desire for safe (culturally appropriate) local care (Not universal)[24]

Despite abundant evidence and a strong policy context that supports 'birth close to home', many rural maternity sites lack sufficient support.

Rural maternity care in BC: challenges and closures

Over the past twenty years, there have been numerous 1A maternity site (no local access to c-section) closures in BC. Figure 1 below depicts recent closures of 1A maternity sites in BC.

Figure 1: 1A Site closures in BC, 2001-2008

The wave of closures is not unique to BC, but is evident in other parts of Canada as well.

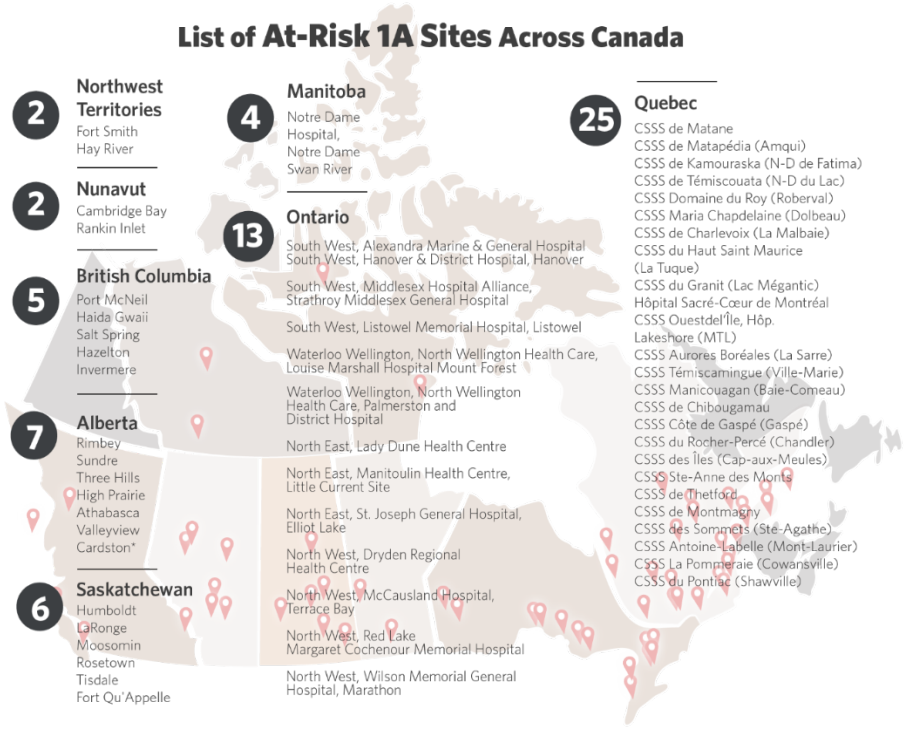


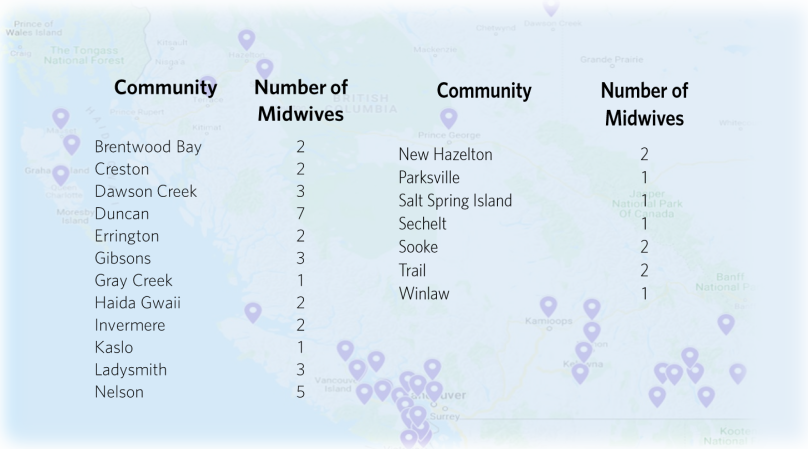
Figure 2: 1A maternity sites at risk across Canada, updated July 2018

Despite the wave of closures, progress is being made in rural maternity care in BC. This includes the spread of registered midwives to rural communities, funding of *Doula's for Aboriginal Families* grant program, innovative inter-professional care team models, funding to support rural surgical and obstetrical networks in BC, the 'Building Blocks' project that aims to look at system supports necessary to sustain low-resource maternity services in BC and the work of a symposium that brought together low-resource maternity care providers in the province.

Rural maternity care in BC: Progress and innovation

Midwifery in BC

Midwifery in rural communities has spread in BC and allowed rural communities increased access to maternity care. Figure 3 depicts rural midwifery communities in BC.



Community	Number of Midwives	Community	Number of Midwives
Brentwood Bay	2	New Hazelton	2
Creston	2	Parksville	1
Dawson Creek	3	Salt Spring Island	1
Duncan	7	Sechelt	1
Errington	2	Sooke	2
Gibsons	3	Trail	2
Gray Creek	1	Winlaw	1
Haida Gwaii	2		
Invermere	2		
Kaslo	1		
Ladysmith	3		
Nelson	5		

Figure 3: Active midwifery practices in rural BC, MABC updated October 2018

Doula's for Aboriginal Families Grant Program

The Doula for Aboriginal Families grant program offers subsidized prenatal, birthing and postpartum doula services. It is supported by the BC Association of Friendship Centers and First Nations Health Authority. The program covers up to $1,000 of coverage for each pregnancy in a family for Aboriginal mothers and families, living in BC (living either on or off reserve).

Apple Tree Maternity, Nelson BC

This maternity care clinic offers collaborative (physician-midwife-allied health) care. The group offers home births as well as group and/or individual care, postpartum support including home visits, a breastfeeding clinic and transition to parenthood support.

Midwifery, Haida Gwaii

FNHA supported midwifery services in Skidegate and Old Masset, Haida Gwaii. The realization of this model was a result of collaboration between the communities of Skidegate and Old Massett, First Nations Health Authority, Northern Health, the local Medical Advisory Committee and the Midwives Association of BC. This is a community-driven, Nation-Based model that provides women-centered care for women on Haida Gwaii.

Rural Surgical Obstetrical Networks funding

The Joint Standing Committee on Rural Issues is funding a project to support vulnerable rural surgical services in BC. This is important for rural maternity care as these surgical services are the foundation for local maternity care in rural sites.

Building Blocks to Sustainable Rural Maternity Care

This project is a two-phased community-based research project. The first phase entailed in-depth community engagement with birthing women, families, elders and community members to understand experiences of maternity care. Out of this came a strong community desire for local maternity care. From here, the project worked with local care providers and administrators to understand what systems supports are needed in order to provide sustainable maternity care to North Island families. Five 'building blocks' emerged from this and are depicted in Figure 4 below.

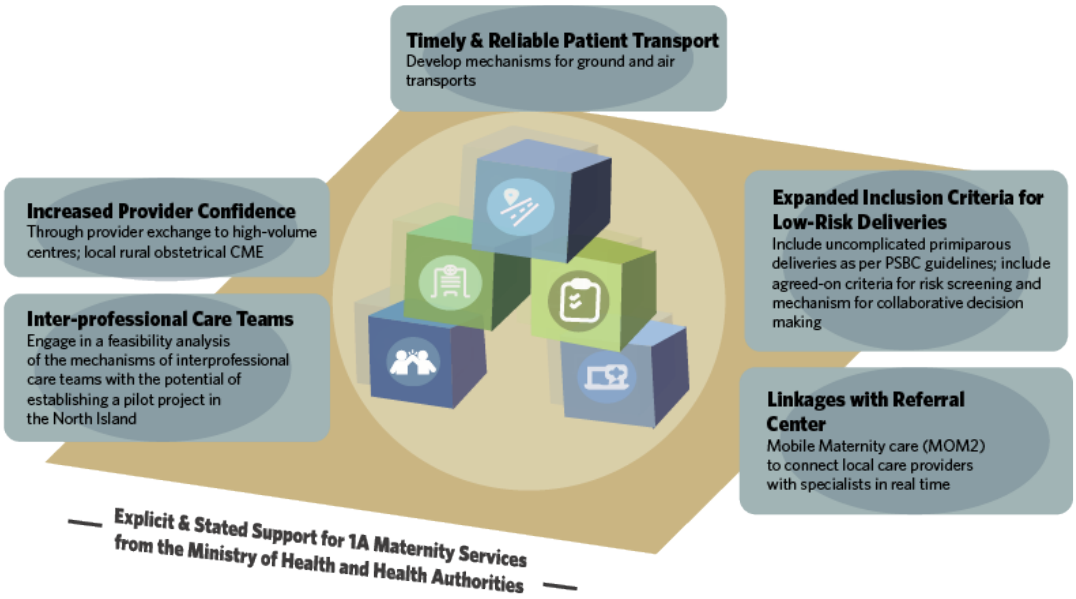


Figure 4: Building blocks to sustainable rural maternity care, North Vancouver Island

Phase two of the project is actualizing the building blocks through a feasibility analysis of each. Recommendations will be disseminated via a project report and relevant knowledge translation activities.

1A Community Symposium, June 2018

Sustaining rural maternity services involves system support from the Ministry of Health and Regional Health Authorities. We brought together a nurse, physician, midwife and the health care administrator from each of the 1A communities (no local access to caesarian section) in BC to understand common challenges and focus on potential solutions. Findings from this symposium was the basis for this second meeting to bring together key policy- and decision makers to action the proposed recommendations. A summary of findings from the 1A Community Symposium are included in Figure 5 below.

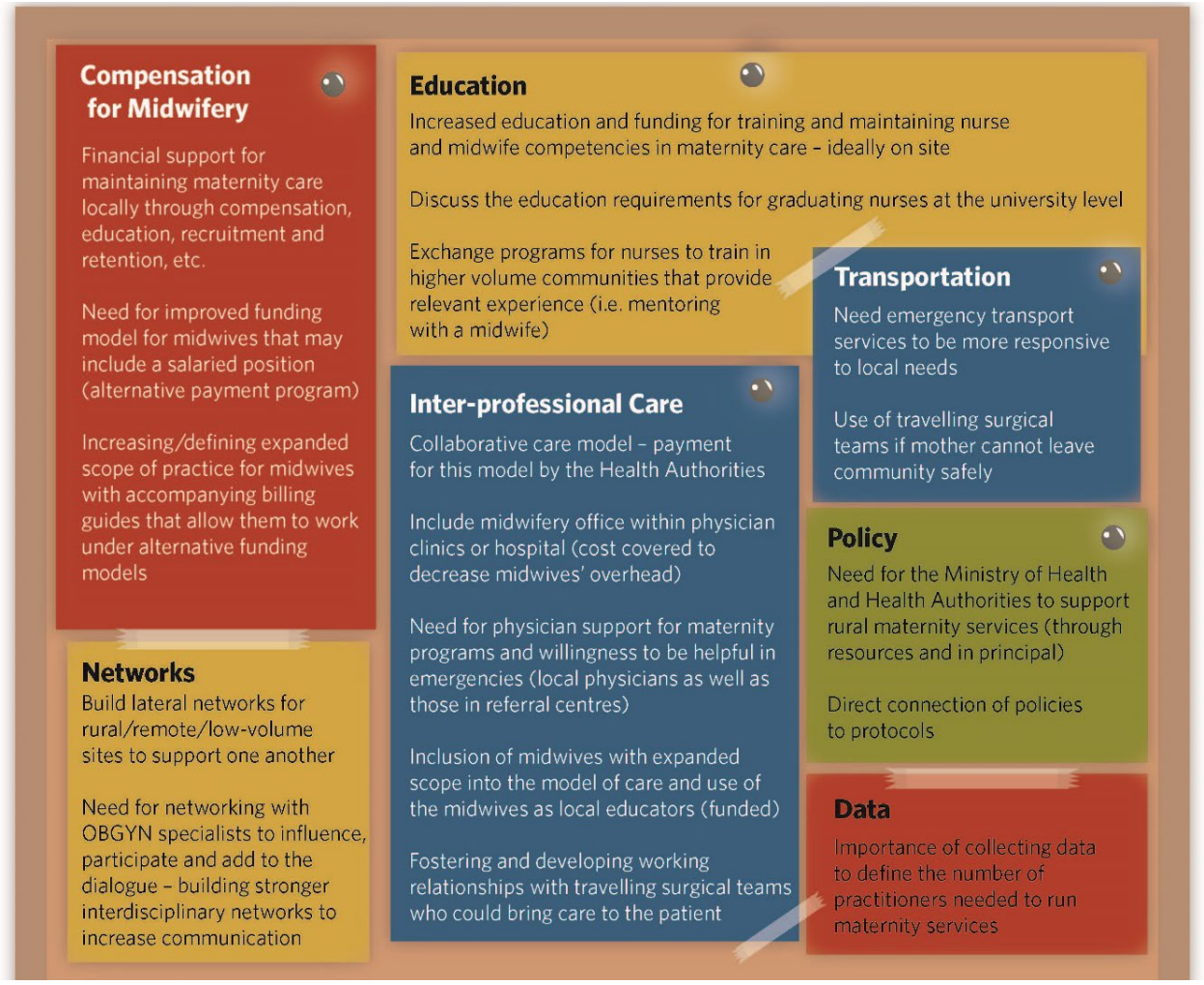


Figure 5: Summary of findings from the 1A Community Symposium that took place on June 15th, 2018

The recommendations arose through a consensus process with all attendees. Key recommendations included:

- Creating strong inter-professional maternity care teams;
- Alternative funding models to support midwives;
- Developing a model for ongoing training and education for rural maternity care nurses;
- Inclusion of midwives into primary care networks

Several participants from the 1A Community Symposium in June were asked to attend the October symposium and bring reflections they had from the day. Erin Price, RMW practicing on Salt Spring Island highlighted key takeaways from the 1A Community Symposium from her perspective as a practicing rural midwife. Erin's key comments included the urgency of midwifery sustainability in rural settings and the need for appropriate funding models to address burn out and a lack of time off call. Hanna Scrivens, Kwakwaka'wakw Maternal, Child and Family Health Project Manager, also was an

attendee at the 1A Community Symposium and re-emphasized the urgency of working to sustain these 1A communities' maternity care services, particularly for Indigenous moms who are disproportionately overrepresented in rural settings.

Understanding current positions and challenges in rural maternity care

Each professional association was given eight minutes to present their current work and challenges faced in regards to rural maternity care. The objective was to generate a shared understanding of system challenges faced in providing low-resource maternity care by each professional body.

Association of Registered Nurses of British Columbia

Michael Sandler
Association of Registered Nurses of BC

Current challenges

- Improving quality care requires education and currently there are barriers for nurses to receive the education they need
- Rural and remote nursing requires unique policy, there are existing barriers in policy that limit opportunity

Opportunities

- Optimizing scope of practice for registered nurses (RN) and nurse practitioners (NP)
- Enhance professional education, support NP and advanced practice registered nurse (APRN) integration into existing structures
- Support nurses in contributing to the health and well-being of their communities
- Champion rural and remote nursing leadership, invest in rural and remote nursing research and knowledge translation

MIDWIVES ASSOCIATION of BRITISH COLUMBIA

Alix Bacon & Jody Medernach
Midwives Association of BC

Current challenges

- Privileging for midwives at primary and referral sites
- Call schedule and burnout, lack of MOCAP funding for midwives and inadequate locum coverage
- Lack of an alternate payment model for midwives
- Challenges accessing Continuing Professional Development opportunities recognizing the large geographic areas midwives are spread across

Opportunities

- Current working group to look at an alternate payment model for rural midwives
- Strong partnership with First Nations Health Authority
- Working towards a student loan forgiveness program that includes midwives who practice in rural

GPSC
General Practice Services Committee

Dr. Shelly Ross
General Practice Services Committee

Knowledge and practice in maternity care used to be a core requirement of physicians. However, things have changed and there is great variance in how physicians may choose to practice, making maternity care no longer a guaranteed skill of a general physician's practice.

Current challenges

- Local physicians need to be interested in providing maternity care
- Local physicians require competency in maternity care as well as 'clinical courage'
- There is a need for inter-professional team support; the job cannot be done as a solo practitioner and requires support from a referral site as well as the local team and external support
- There is a need to build resiliency in local providers for when things do not go as expected

Opportunities

- GPSC Primary Care Networks:
    - Maternity care is a priority of the network
    - Working to this end by developing a video to disseminate to ensure regions are planning to include maternity care in service plans
- GPSC Maternity Care for BC:
    - Work to improve clinical confidence
    - Mentorship program to support clinicians
    - Offer refreshers for clinicians
    - Perform practice ready assessments for physicians

Understanding current positions and challenges in rural maternity care

Similar to the preceding presentations, the Ministry of Health and each Health Authority were asked to present opportunities and challenges in sustaining rural maternity care in their region. The objective was to generate a shared understanding of system challenges each face in order to better understand where there may be opportunities for partnership.

Ministry of Health

Glenys Webster & Cheryl Martin

Members of the Ministry of Health had the opportunity to visit the North Island and hear from moms themselves of the importance of birth 'close to home'. Since then (spring 2018), members of the Ministry of Health have been gathering people together in hopes of collectively moving this work forward.

Members of the Ministry of Health stated that these conversations regarding sustaining 1A maternity services in BC are being heard and worked on. Currently, the Ministry is at a "time of profound transformation for maternity care". The Ministry of Health's role is to provide strategic policy direction

for sustainable rural maternity care in BC. Rural maternity care and the Ministry of Health strategic agenda include:

- Prioritizing interdisciplinary team-based care
- Commitment to reconciliation – adoption of the United Nation's Declaration on the Rights of Indigenous Persons and the Truth and Reconciliation Commission
- Implementing Primary Care Networks
- Working towards reducing surgical wait times; caesarian-sections being a major focus
- Research funding to develop a Rural Birth Index – a tool to estimate/predict the appropriate level of maternity service for a given rural population based on population characteristics and isolation score

Northern Health

Vanessa Salmons

Northern Health is committed to supporting rural services and primary care providers. Education is at the top of planning priorities and they would like to create both local and remote learning opportunities. A summary of key points presented by Northern Health are listed below:

- Require partnership and participation between primary maternity care, providers and the Health Authority for strengthened rural maternity education
- Providers must be committed to providing low-risk maternity care
- Education curricula must be designed community by community to balance meeting the needs of the community with patient safety and quality care
- Reliable transportation remains a challenge
- Alternative funding for midwives is a priority - currently undertaking a review to understand opportunities, gaps, and retention for maternity care providers
- Need to overcome the barriers nurses face in receiving adequate training for low-risk deliveries
- Utilize midwifery as an educational tool for health care providers (nursing)

First Nations Health

Dr. Unjali Malhotra

First Nations Health Authority (FNHA) focuses on mothers, babies, community, and land. FNHA acknowledges that a woman knows her body and the risks of her birth. They stand by women who wish to travel and look for collaboration that promotes safety, choice, and voice.

FNHA believes that cultural safety includes allowing women to deliver at home in their own communities and supports working towards building a system that offers services closer to home to support women's informed choices and to support the best care. FNHA is working towards the following items:

- Informed choice for rural women
- Inter-disciplinary relationships to provide better care
- Increased awareness and education for culturally safe care
- Increased support for Indigenous health care providers
- Relationship building for health care providers
- Review and revisit travel supports for when women need to leave their community to give birth

Island Health

Erin O'Sullivan

Island Health is looking to apply a quality structure in its support for the rural context of maternity care. Island Health is hoping to have outreach programs at tertiary sites to support their rural sites. There is a recognition and focus to support rural sites and affirm them in what they do well and strengthen supportive relationships between rural and referral sites. This was articulated "we [referral sites] tell rural health services what they have done wrong, but we fail to tell them what they have done right." Continuous positive and constructive feedback is needed to sustain and improve these networks as well as ensuring the voices of all involved are considered.

Interior Health

Robert Finch

Interior Health has developed the Maternal, Newborn, Child, & Youth Network. This is a structure that will help address current gaps in care. The Steering Committee will work to address the current state of maternity care in Interior Health and the challenges associated with losing maternity services in some Interior Health sites. In April of 2018, 100 Mile House suspended maternity services in the

community. There is recognition that the closure of one site not only impacts the local community, but also creates sustainability issues at the larger referral sites, such as Kamloops in this case, and has put strains on other health care providers.

Currently, they are looking for innovative sources of funding and to introduce new strategies to improve the system including the introduction of shared care strategies.

Rural Maternity Sites in BC
Working Together Towards Sustainability

LIVE GRAPHIC RECORDING BY ANNALEE KORNELSEN VISUAL PRACTITIONER

Opportunities for collaboration: *Actions supporting change an addressing challenges*

"It is clear that when you create the space to have meaningful and respectful dialogue, regardless of what the outcome is, the fact this space has been created is extremely advantageous. Even if we don't come up with a streamlined solution, we come out with a more open-minded model of care"

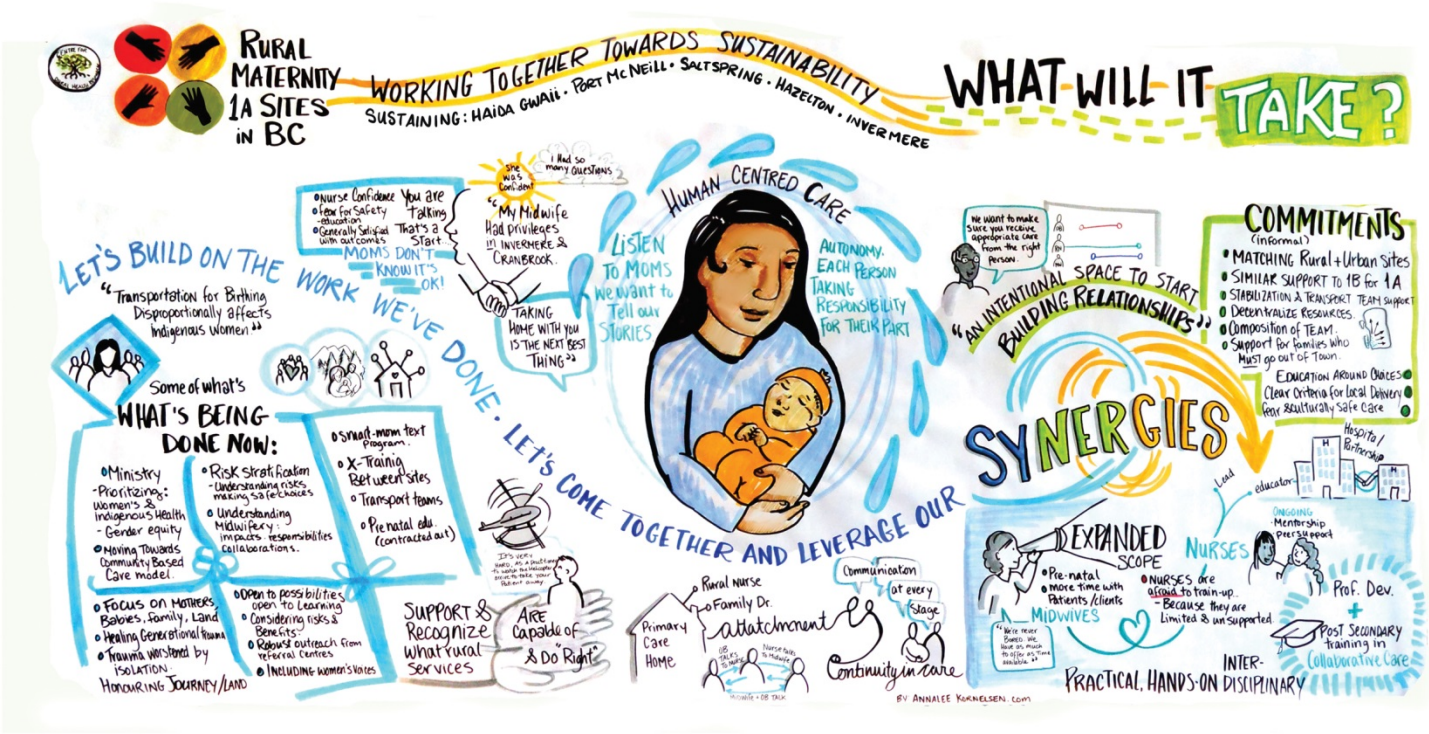
Following the morning presentations, the afternoon was spent in a large group discussion. The discussion focused on innovative solutions to sustain rural 1A maternity services in BC. Attendees acknowledged the 'good work' done in the last ten years, but also recognize continued work needed to ensure equitable care for rural women in BC. The following table is a summary of the discussion.

Item	Discussion points
Primary Care Networks (PCN)	• Maternity care cannot be an afterthought to the development of PCNs • Some patients are attached to a single service provider throughout their pregnancy and for PCNs to play a critical component in the future, there should also be a focus on finding a primary provider for mothers • Necessity of making sure midwifery is part of the PCNs in a foundational way • Importance of creating a network structure that puts patients (moms) at the center
Alternative payment models for midwives in rural practice	• Recognition that we need a 'just in time' solution for midwife sustainability in rural low-resource communities in BC • Alternative payment model needs to be funded for low-volume midwifery practices • Recognition that alternative payment models may not be a 'one-size-fits-all' solution in rural communities, but are a necessary start
Maternity practice in rural	• We cannot simply apply an urban framework to rural sites as has been the case historically – this is failing rural sites • What if we consider rural differently, and approach solutions in light of "complex adaptive systems" approach • Embedded constraints to moving forward to sustaining rural maternity care include money, inter-professional anxiety and competitiveness
Midwifery regulation and practice	• Midwifery in rural communities must include an expanded scope of practice • There is a gap where some rural midwives are not privileged at larger referral centers, making for challenges in transferring care
Networks of support	• Necessity of reciprocal training/experience for care providers in 1A communities and referral sites • Matching small sites with larger sites for mutual support and education (particularly for nursing) would serve to strengthen low-resource sites
Rural perinatal nursing education	• Recognition of the vital role nurses play in the patient's care journey and experience • Ongoing nursing training/education is important in maintaining nursing confidence and a strong inter-professional maternity care team

	• Midwives are well situated to provide ongoing local perinatal nursing education in rural communities and need funding avenues to support this mode of education • Increased nursing confidence is significant for inter-professional maternity care teams as well as for conveying confidence in a safe maternity service to mothers and to the larger community • Graduating Registered Nurses (RNs) lack a strong maternity foundation, which needs to be addressed at the post-secondary institution level • Rural perinatal nursing education needs to be grounded in hands-on practical experience • Some RNs who get further training are then seen as 'experts', which can accentuate stress in a low-resource setting • Nurses need to be included in clinical coaching and ongoing Continuing Professional Development (CPD) in their local community
Inter-disciplinary relationships	• Inter-professional programs in academia need to allow more time for on the ground practical experience working in teams (as opposed to text-book based case studies) • Inter-disciplinary training needs to continue in terms of CPD • Building strong relationships underscores safe maternity care (i.e. moms, midwives, nurses, doctors… etc.) • Apple Tree maternity in Nelson is an excellent example of an inter-professional model with pooled funding, allowing providers to provide care in a meaningful and sustainable way
Transport	• How can we improve/advocate for improvements in transport? • What can be done within regions in terms of support for transport? • Challenges may be attributed to a lack of distribution of transport resources with all transport resources in one place geographically • Bringing expertise to the rural communities may be the appropriate solution in some cases, however there is no "one size fits all" solution
Changing attitudes towards birth	• There are gaps in communication/education regarding choice in place of birth for rural women • Communities need to work locally to raise awareness around the choice in place of birth • Discussions around patient autonomy and clinical and cultural decision making need to take place in rural communities • The health care team needs to share the discussion of patient autonomy as a team so that the team are all aware and share responsibility

Next steps

Next steps include follow up with each key stakeholder to begin to action proposed discussion items as appropriate within each sphere of influence. These tangible outputs will be included in a framework that will be disseminated to key-stakeholders and decision-makers.



Patient Partner on Day's Discussions

"We sometimes feel like we don't really matter because we are low volume, it is huge that you guys are sitting around this table now, but the real proof will come in the form of action." *-Rachel*

Rachel Caswell is a mother of two from Invermere, BC who closed the meeting by commenting on the day and her feelings of 'hope' for the future of rural maternity services in BC. Rachel delivered her first child in the regional referral center and her second locally in Invermere and has hopes of using local maternity services again as she considers expanding her family yet.

Rachel highlighted several **challenges** she and other of her friends encountered delivering locally:

- High turnover of nursing staff in low-resource communities can leads to a lack of relationship and connection between mom and care providers
- Local nurses often lack the confidence and competence in maternity care which is conveyed to birthing moms and leads to questions of safety
- Care providers may lack of experience in maternity care due to a low-volume environment
- There is always a fear of safety when moms need to travel farther, particularly because transport is often unreliable

Rachel also spoke to the **advantages** of delivering locally, including:

- Ability to reunite with family hours after giving birth
- Not having to be away from home for a month or more to deliver in a referral community
- Being able to deliver when appropriate and not have to hold off delivering due to long transportation time to a 1B site could have meant less complications during her labor
- Familiarity with hospital staff and community

Rachel concluded with her **hopes** for rural maternity care in BC:

- That midwives get the support they need to sustain their services
- That no more maternity sites are closed
- That interdisciplinary teams are supportive and cohesive
- That nurses get the necessary training and education to provide competent maternity care
- That moms and the local community receive education on what it means to birth locally in a low-resource setting

"My hope for this group is that midwives can continue to work and receive adequate support and that low volume maternity settings can continue to receive funding to grow. I hope that care providers continue to encourage women to deliver locally, and that nurses can get the appropriate confidence to deliver babies." *- Rachel*

Attendees

Organization	Position
Vancouver Coastal Health	
Janet Walker	Regional Director
Island Health	
Erin O'Sullivan	Regional Perinatal Program Development and Evaluation Lead
Jill Pearman	Department Head - Midwifery
Dr. Hayley Bos	Maternity Care and Pediatrics Division Head
Interior Health	
Rob Finch	Director, Maternal Child & Youth Network
Dr. Jill Boulton	Medical Director, Perinatal & Neonatal Network
Northern Health	
Vanessa Salmons	Executive lead, Perinatal Program
First Nations Health Authority	
Hanna Scrivens	Project Manager, Kwakwaka'wakw Maternal, Child and Family Health
Kayla Serrato	Senior Policy Analyst, Policy Planning and Transformation
Barb Webster	Clinical Nurse Specialist, Maternal Child Health
Dr. Unjali Malhotra	Medical Officer, Women's Health
Shannon McDonald	Deputy Chief Medical Officer, CMO Office
BC Emergency Health Services	
Amy Poll	Superintendent/ Manager, Patient Care Delivery
Patient partners	
Jessica McLaughlin	North Island Mom
Rachel Caswell	Invermere Mom
1A Care providers	
Erin Price	Midwife Salt Spring

Organization	Position
Professional Associations	
Michael Sandler	Chair of the Rural and Remote Policy Table
Valerie St. john	Executive director, Association of Nurses and Nurse Practitioners of BC
Jody Medernach	Vice President, MABC
Alixandra Bacon	President, MABC
Shelley Ross	GPSC Committee Member
BC Ministry of Health	
Glenys Webster	Director Women's, Maternal and Early Childhood Health
Sara Amyot	Assistant Manager, Women's and Maternal Health
Dr. Michelle Barros Pinheiro	Senior Policy Analyst Women's and Maternal Health
Wendy Trotter	Executive Director
Karen Ramsay Cline	Manager, Indigenous Health
Kacie Poskitt	Policy Analyst, Indigenous Youth Internship Program Intern
Christine Therriault-Finke	Manager, Chronic Pain
Cheryl Martin	Director, Rural Primary Care Lead
Other	
Dr. Stefan Gryzbowski	Rural Physician
Lisa Sutherland	Primary Maternity Care Lead, Midwifery PSBC
Jana Encinger	Provincial Director, Clinical Quality and Systems Improvement, PSBC
Kim Williams	Network Director, RCCbc
Dr. Jeanette Boyd	Lead for the Rural Obstetrics Network at RCCbc

Agenda

Time	Item	Lead
9:30am	*Attendees are welcome to arrive early for coffee and pastries*	
10:00am	Opening Remarks • Welcome • Territory acknowledgement • Introductions: *"Your best birth experience"*	Jude Kornelsen
10:30am	Patient partner speaks: *"Importance of local birth"*	Jessica McLaughlin (Port McNeill)
10:40am	Context setting • Share background and findings from 1A Community Symposium: *Establishing building blocks to sustain rural maternity care in BC* • Reporting back from 1A community representatives	Jude Kornelsen to lead
11:10am	Understanding current positions and challenges regarding rural maternity care: Professional Associations present *(8 min each)* • Association of Registered Nurses of BC • Midwives Association of BC • General Practice Services Committee	Jude Kornelsen to introduce Michael Sandler Alix Bacon and Jody Medernach Dr. Shelly Ross
11:40am	Understanding opportunities and challenges in sustaining rural maternity care: Health Authorities present *(8 min each)* • Ministry of Health • Northern Health Authority • First Nations Health Authority • Island Health Authority • Interior Health Authority • Vancouver Coastal Health Authority	Jude Kornelsen Glenys Webster & Cheryl Martin Vanessa Salmons Dr. Unjali Malhotra Tbd Robert Finch Janet Walker
12:30pm	*Networking lunch* *Video presentation from the Shared Care Committee*	
1:10pm	Discussion Opportunities for collaboration: Actions supporting change and addressing challenges	Group discussion
2:20pm	Next steps	Group discussion
2:45pm	Patient partner on the day's discussions	Rachel Caswell (Invermere)
3pm	*Event close*	Jude Kornelsen

References

[1]Kornelsen J, McCartney K. The safety of rural maternity services without local access to cesarean section. Applied Policy Research Unit, University of British Columbia. 2015.

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