Annual Report 2015/16

Perinatal Services BC
An agency of the Provincial Health Services Authority

About Perinatal Services BC

Perinatal Services BC (PSBC) provides leadership, support, and coordination for the strategic planning of perinatal services in British Columbia. PSBC collaborates with the Ministry of Health, health authorities, and other key stakeholders. Perinatal Services BC is the central source in the province for evidence-based perinatal information.

Vision

Healthy women having healthy pregnancies and infants.

Mission

Through partnerships and collaboration and by building a high quality system of care across the continuum, we will optimize pregnancy and birth outcomes as a foundation for a healthy population.

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Message from the Provincial Executive Director

I am pleased to present our **Annual Report for 2015/16** showcasing the work and accomplishments of Perinatal Services BC (PSBC). The 2015/16 fiscal year was another year of hard work and never ending change for our Perinatal Services BC team.

In order to better align our work with the strategic priorities of the Ministry of Health, our team was slightly reconfigured into more streamlined work themes, each led by a director. These areas are:

- Provincial Health Promotion, Prevention, and Primary Care;
- Provincial Knowledge Transformation and Acute Care; and
- Provincial Registry, Surveillance, Performance, and Analytics.

Along with the reorganization of teams, we were happy to welcome a significant number of new staff to our team. Some replaced positions left open due to retirement, some filled existing vacancies, and others stepped into newly created roles. We have a full and very dedicated and hardworking team.

We continue to work closely with BC Women's Hospital, our provincial stakeholders, and the Ministry of Health through the PSBC Steering Committee and other venues to advance maternal and newborn health on a population level. PSBC's work supports the strategic policy direction outlined by the Ministry in *Setting Priorities for the BC Health System* and advances the key priority areas to better meet the needs of the women and families that the system serves.

PSBC leads initiatives that advance maternal and newborn health services in the areas of team-based primary and community care, including access to specialized services and support for physicians and allied health professionals in rural areas. Normalizing birth, sustaining rural maternity and surgical services, and advancing the Baby-Friendly Initiative are significant examples of strategic priorities that PSBC has been working closely with health authorities to achieve, and we will continue to do so over the coming year.

Throughout the year, we have continued to refine and improve our surveillance processes and collaborate with many stakeholders, including regional health authorities, First Nations Health Authority, the Ministry of Health, and professional associations, to work towards our vision of healthy women having healthy pregnancies and infants. We ended with a successful and engaging conference, leading us into the new year with a renewed sense of energy and commitment.

I hope you enjoy reading this report.

Kim Williams, RN, MSN
Provincial Executive Director

Health Promotion, Prevention & Primary Care

We collaborate with frontline leaders in community, primary care, and acute care settings across the province, as well as the Ministry of Health, health authorities, and national organizations to lead the development and implementation of best practice initiatives that promote healthy pregnancies and healthy infants.

Training for Healthy Pregnancy Weight Gain

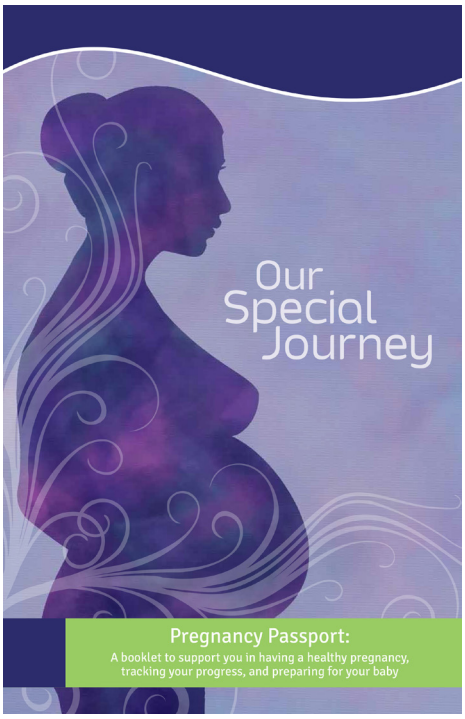
Led by Perinatal Services BC, a provincial working group completed development of a training strategy for the primary care practice support tool, the *5As of Healthy Pregnancy Weight Gain*, which was developed by the Canadian Obesity Network.

Training is designed for family physicians, obstetricians, nurse practitioners, midwives, and dietitians in BC and across Canada. The online training is free and accredited.

After completing the training, care providers will be able to:

- highlight the importance of healthy gestational weight gain;
- counsel patients about healthy pregnancy weight gain;
- develop a practical approach for applying the 5As framework in a busy health care setting; and
- identify resources to support the adoption of behaviours that facilitate healthy weight gain during pregnancy.

PSBC and the UBC Division of Continuing Professional Development are also hosting eight regional workshops across BC during the 2016/17 fiscal year.



Our Special Journey: Pregnancy Passport

PSBC launched a refreshed pregnancy passport for women. *Our Special Journey: Pregnancy Passport* is a booklet that supports women to have a healthy pregnancy, track their progress, and prepare for their baby.

The Pregnancy Passport includes:

- information relating to the woman's needs and the care she can expect throughout her pregnancy, birth, and after the baby is born;
- a place to record check-ups and tests;
- places to write down goals, questions, ideas, decisions, and hopes and dreams for her baby; and
- a list of resources.

The passport was adapted from the 2011 Women's Health Pregnancy Passport and informed by the 2015 Aboriginal Pregnancy Passport.

Aboriginal Health

Perinatal Services BC is working more closely with the First Nations Health Authority. Together, we are reviewing maternal and child health programs and training to ensure they are relevant to the First Nations population they serve.

Other projects include:

- creating a data access request on the First Nation client file from the Ministry of Health for surveillance and reports;
- working with regional health authorities to develop policy statements on cultural safety and humility;
- developing an Aboriginal maternal health project for north Vancouver Island; and
- helping doula supervisors support the practice and certification of their doulas.

Screening Programs

Prenatal Genetic Screening Program

Non-Invasive Prenatal Testing

In October 2015, the Ministry of Health approved funding for non-invasive prenatal testing (NIPT) for eligible women at high risk for Down syndrome, trisomy 18, or trisomy 13. As of November 2015, pregnant women who meet one of the following three criteria are being provided with the option of NIPT:

- has received a positive screen result from IPS, SIPS, or Quad testing;
- has had a previous trisomy 13, 18, or 21 pregnancy; or
- has a risk of Down syndrome greater than one in 300 based on results of screening and ultrasound marker(s) of aneuploidy.

In March 2016, the Prenatal Genetic Screening Program selected Dynacare Next, provider of the Harmony test, through a Request for Proposal process as the sole vendor for funded NIPT for these eligible women. PSBC and Dynacare developed a special lab requisition for ordering funded NIPT, and multiple blood collection sites across all BC health authorities were set up for the Dynacare Harmony test.

Women who do not meet the eligibility criteria for funded NIPT but are interested and prepared to cover the cost of self-pay testing (ranging from $495 to $650 depending on the supplier) are encouraged to consult with their health care provider to have their blood drawn at a location offering NIPT.

PSBC's website includes information on both funded and self-pay NIPT options.

Patient Pamphlets

PSBC updated two patient pamphlets, *Prenatal Genetic Screening: It's Your Choice* and *A Screen Positive Result: What does it mean and what do I do now?* They were previously available in English and six other languages. The new versions were also translated into Arabic and Persian.

Newborn Screening Program

An online training module is in development for all BC lab staff as a quality improvement initiative to reduce errors in completing blood spot cards, thus improving the quality in screening and reducing the need for re-collections. The training module is expected to be available through health authority online learning hubs later in 2016.

22 disorders screened

A business proposal has been submitted to the Ministry of Health to enhance the newborn disease panel to include three new conditions, which will then meet the national standard recently established for newborn screening across Canada.

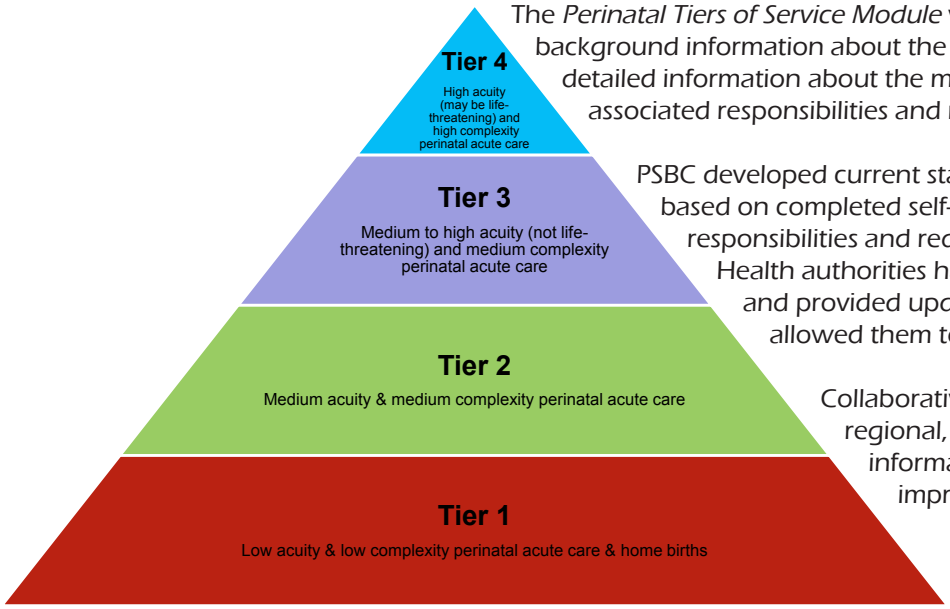
Biliary Atresia Home Screening Program

84,000 stool colour cards ordered by hospitals

Perinatal Services BC continues to provide ongoing education to health care providers and parents about the Biliary Atresia Home Screening Program for newborns.

System Planning

Perinatal Tiers of Service



The *Perinatal Tiers of Service Module* was finalized in January 2016. It includes background information about the Perinatal Services BC framework and detailed information about the maternal/fetal and neonatal tiers and associated responsibilities and requirements.

PSBC developed current state summaries for each health authority based on completed self-assessments of their ability to meet the responsibilities and requirements at various tiers of service. Health authorities have reviewed and validated their reports and provided updates on initiatives or changes that have allowed them to eliminate some of the gaps.

Collaboratively, we have been able to identify local, regional, and provincial gaps and will utilize the information for future planning and quality improvement.

Interprofessional Primary Maternity Care Collaboration

In 2014, Perinatal Services BC was asked by the Ministry of Health to conduct an environmental scan of existing primary maternity care collaborations across BC to explore and document the innovation, knowledge, experience, and diversity of collaborative service models that have emerged in recent years. For over a decade, interprofessional collaborative practice has been widely promoted as an effective and efficient way to improve the quality and sustainability of primary maternity care. Research has shown that this type of practice can improve women's access to care, quality of care, and care provider satisfaction and retention. It is woman-centred care that is responsive to the needs of families and communities.

- **8** practice groups
- **4** midwives
- **5** physicians
- **2** admin coordinators

The Art of the Possible is a three-phase PSBC project to explore and enhance interprofessional collaboration in primary maternity care across BC. During the first phase of the project, PSBC conducted semi-structured interviews with primary care providers and administrators currently working in collaborative practice environments. There are a number of primary maternity care providers in BC demonstrating remarkable innovations in interdisciplinary collaborative practice design. Respondents described their practice profile and demographics, identified the most important local issues faced by women and providers, and shared their interdisciplinary, collaborative strategies.

Eight practice groups were represented in interviews with four registered midwives, five family physicians, and two administrative coordinators. Each practice was unique in its model of collaboration, with collaborative designs affected by community needs, resource availability, provider characteristics, and health authority support. Perspectives from urban, near-urban, and rural practice

environments were included. This first phase of the project produced valuable information, including a number of enablers and key success factors to support the development and sustainability of collaborative interprofessional primary maternity care across BC.

The second phase of the project is to conduct a deeper dive, looking at additional practices, collaborations that have tried but were unsuccessful, emerging collaborations, and networks. The third phase will be knowledge translation, including development of resources, workshops, and a community of practice for interdisciplinary, collaborative care in BC.

Sustainment of Rural Maternity and Surgical Services

Perinatal Services BC continues to work closely with the Rural Coordination Centre of BC and the community of practice of health administrators, health care providers, academic institutions, policy makers, and community members to develop solutions to help sustain maternity and surgical services in rural and remote communities.

The evidence shows that forming strong networks between communities to serve the population in a geographic area is a model that can contribute to sustaining services. In a network, the local surgical program is a geographic extension of the regional centre. Colleagues are linked through professional relationships and referral patterns. When local resources are appropriate to a patient's anticipated needs, the care is given as close to home as possible. The network model ties in with the Perinatal Tiers of Service Module as it supports all tiers within a region to support each other to meet the needs of women and infants.

In January 2016, PSBC attended the Summit on Rural Surgery and Operative Delivery in Banff, which included representatives from government, health authorities, researchers, providers, universities, and national associations. Seventy-five participants came together to build on the work being done in BC and other provinces. Five working groups were formed to address:

1. training and accreditation standards for physicians to have enhanced surgical skills;
2. a toolkit for the above;
3. development, implementation, and evaluation of networks;
4. credentialing and privileging processes; and
5. a standard curriculum to teach cesarean section to rural family physicians.

The work of these groups will be foundational as we collectively move forward together to address this important planning and service issue.

Photo of Ashcroft courtesy of Government of BC

Provincial Home Birth Supplies Program

In 2015, the Midwives Association of BC (MABC) and the Ministry of Health signed an agreement to establish a new home birth supplies program to address concerns regarding care provider access to supplies, medications, and sterilization services needed for home births. Perinatal Services BC was asked to lead this initiative and formed a working group with representation from MABC, Ministry of Health, health authorities, and physicians to develop the program proposal.

While the identified concerns were historically a midwifery-only issue, the intent of this initiative was to develop standard processes that could be used for all care providers attending home births. In addition, the data collection process for home births had been cumbersome and inefficient; improved data collection would ensure that regional health authorities had access to timely data.

The new Home Birth Supplies Program came into effect on April 1, 2016. It is a standardized provincial program for all care providers attending home births to access supplies, medications, and sterilization (reprocessing) services. One key aspect of the program is ordering the bulk of disposable supplies, medications, and reusable equipment through the provincial Product Distribution Centre, resulting in cost efficiencies. In addition, the hospital where the pregnant woman is registered will provide, clean, and sterilize equipment used during a home birth. Finally, the program will also integrate home birth services into health authority and provincial planning through an improved data collection process.

Knowledge Transformation & Acute Care

Perinatal Services BC develops, adopts, and approves guidelines and standardized forms that support best practices for maternal and newborn care using a multidisciplinary approach. We collaborate with provincial stakeholders and frontline leaders to promote the application and integration of evidence-based best practices designed to increase the effectiveness, efficiency, accountability, and sustainability of clinical activities in maternal, fetal, and newborn health across British Columbia. We also coordinate and provide outreach education for fetal health surveillance, neonatal resuscitation, and acute care of at-risk and unwell newborns.

Healthy Mothers and Healthy Babies Conference

PSBC's 2nd Biennial Conference, **Healthy Mothers and Healthy Babies: Advances in Clinical Practice and Research Across the Continuum**, was held in Vancouver on March 11-12, 2016. With 338 delegates and a range of topics and participants, the conference was engaging and inspiring.

The majority of attendants were from BC, but there was also representation from Alberta, Saskatchewan, Manitoba, Ontario, Quebec, Newfoundland, Nova Scotia, Prince Edward Island, Yukon Territory, United States, United Kingdom, Australia, and Saudi Arabia. Nurses accounted for 39% of participants, followed by students (10%) and administrators/managers (10%), educators (8%), midwives (6%), and physicians (5%). There were also researchers, lactation consultants, social workers, epidemiologists, dieticians, doulas, pharmacists, physical therapists, support workers, and outreach workers, among some other professions.

Our plenary speakers were:

- Darci Lang – *Focus on the 90%*;
- Tamara Taggart – *What Makes Good Health Care: A Mother's Perspective*;
- a panel with a midwife, obstetrician, family physician, registered nurse, and mother – *Normalizing Birth from Policy, Practice, and Lived Experience*; and
- Gabor Maté – *The Biology of Loss: Recognizing the Consequences of Impaired Attachments and Fostering Resilience*.

Concurrent session topics spanned the pregnancy, birth, postpartum, and newborn continuum and included gestational weight gain, gestational diabetes, labour and birth, perinatal mental health, breastfeeding, infant sleep, collaborative primary maternity care, infectious diseases, mother/baby care, and rural services.

To encourage viewing of posters, we held a Poster Passport contest. Participants answered a series of questions about the posters in the Poster Passport and entered their completed passports into a draw. We also held a Twitter contest for the best tweet each day. There were over 400 tweets and retweets using the conference hashtag #HMHBBC.

- **338** delegates
- **4** plenary sessions
- **48** presentations
- **89** speakers
- **19** posters
- **400** tweets
- **30** prizes

We are proud to report that the overall rating of the conference based on participant evaluations was high (four out of five). The agenda offered a diversity of topics and speakers of interest to a wide range of professionals, with content delivered in a balanced mix of plenary presentations and concurrent sessions. It was clear from participants' feedback that the sessions were of value due to the quality of speakers and richness of discussions. Two of the most highly evaluated sessions were *Normalizing Birth* and *The Biology of Loss*.

"Great that you had a mother's story up there! To ground research in experiential knowledge. I love the rise of collaborative care!" (Doula)

"Very interesting for someone who works with pregnant and parenting women not within the health care world." (Family Support Worker, Pregnancy Outreach)

"Appreciated hearing from rural/smaller centres about interprofessional collaboration. So important to know and respect each other." (Lactation Consultant/Nurse)

"Very excited to finally hear Dr. Maté speak after reading his book When Body Says No. Great ending to the conference!" (Nurse)

"I can't get enough of Dr. Maté. Policy—that's what we need to work on from here!" (Lactation Consultant)

"Excellent session. Thought provoking and look forward to going home and further reflecting on the message and connecting with friends, family and colleagues to share and discuss." (Social Worker)

Participants also appreciated the networking opportunities, sharing a wealth of ideas and resources they could bring back to their communities and practices. Many indicated that the conference would change their practice:

> "Greater awareness about where we are going as a province and a country." (Physician)
>
> "It open[ed] my eyes on a way of nursing. As a student, I hope to bring many of these aspects into my career!" (Student)
>
> "I made some lovely contacts/networking with nurses from other rural communities and plan to share resources and helpful information." (Nurse)
>
> "I will be offering a presentation to my prenatal group on circumcision and feeling more confident about 1:1 conversations on this topic." (Pregnancy Outreach Coordinator)
>
> "It will inform my policy work." (Midwife)
>
> "As a clinical educator, I can't wait to share the many things I learned with my team." (Nurse)
>
> "Hearing a variety of perspectives opens your eyes to other ways of working. Also the representation of various communities was great!" (Educator)

Thank you to our PSBC Conference Planning Committee, staff, speakers, and participants for a great event!

Visit perinatalservicesbc.ca for:

- Videos of Plenary Speakers
- Conference Photos
- Twitter Story

Fetal Health Surveillance

2 workshops

30 participants

3,400 new users

PSBC held two Fetal Health Surveillance (FHS) Instructor Workshops during the 2015/16 fiscal year in Vancouver and Smithers, with 30 participants (21 nurses, six midwives, and three physicians).

The online version of *The Fundamentals of Fetal Health Surveillance: A Self Learning Manual* continues to gain popularity, with the addition of 3,400 users from April 1, 2015 to March 31, 2016, for a total of 8,500 users from across Canada.

The National FHS Surveillance Steering Committee, co-chaired by BC and Ontario, has been meeting regularly. There are three working groups on revising the eight-hour workshop, creating a refresher course, and developing a bank of case studies.

Newborn Eye Prophylaxis

Through stakeholder communications, PSBC reminded practitioners that screening for gonorrhea and chlamydia in the first trimester is a standard of practice, and the results and any relevant treatment should be clearly written on the antenatal record.

PSBC revised the *Newborn Eye Prophylaxis and Prevention of Ophthalmia Neonatorum Guideline*, which includes clinical significance, risk factors, eye prophylaxis and procedure to administer, and considerations around refusal of eye prophylaxis treatment. While eye prophylaxis is still required in BC by law, parents—after being informed of its risks and benefits—can decide if they want their baby to receive the treatment. If they decide against it, they must sign a *General Release from Responsibility Form*. A sample form is included in Appendix A of the revised guideline, and a Microsoft Word version of the sample form is available on the PSBC website for health authorities to customize with their logo.

Neonatal Resuscitation Program

2 workshops

25 participants

PSBC provided two Neonatal Resuscitation Program (NRP) Instructor Workshops in 2015/16. These are intended for expert-level practitioners who are supported by their facilities to teach neonatal resuscitation in their facilities. The workshops were held in Vancouver and Victoria, with a total of 25 participants (15 nurses, seven physicians, and three respiratory therapists).

In addition, three Regional Instructor Trainers were developed for two health authorities. The primary role of the NRP Regional Instructor Trainer is to assist NRP Instructors meet provincial and regional needs.

Acute Care of At-Risk Newborns (ACoRN)

9 workshops

142 participants

Acute Care of At-Risk Newborns (ACoRN) is a Canadian neonatal stabilization program designed for the multidisciplinary team who—regardless of experience or training in neonatal emergencies—may be called upon to care for at-risk and unwell newborns as well as babies who have been resuscitated at birth. In 2015/16, PSBC offered nine ACoRN workshops with 142 participants (64 nurses, 24 physicians, 53 midwives, and one respiratory therapist).

Supporting Breastfeeding

PSBC collaborated with the Ministry of Health to develop a report summarizing the discussions and outcomes of the Provincial Breastfeeding Think Tank in 2015. The report had five broad themes:

1. policy and leadership;
2. breastfeeding support services;
3. educational initiatives and capacity building;
4. breastfeeding promotion and public education; and
5. monitoring, surveillance, and evaluation.

Each theme included the BC context, priorities, and recommendations from participants. The report was shared with health authorities.

While BC has made substantive strides in advancing breastfeeding and the implementation of the Baby-Friendly Initiative (BFI), an overarching provincial breastfeeding plan is needed to move forward in a collective and coordinated fashion, focusing on key priorities that support breastfeeding families and improve health outcomes for mothers, infants, and families in BC. In January 2016, PSBC recruited a Provincial Coordinator, BFI to work with health authorities and across disciplines to collectively advance breastfeeding and BFI on a provincial level.

Informal Human Milk Sharing

When a mother's own milk is unavailable or unsuitable, the recommended substitute is pasteurized donor milk from a regulated milk bank. However, due to limited supplies and challenges with distribution, this milk is prioritized for premature and ill infants, leaving many parents to seek other options.

Informal (or peer-to-peer) milk sharing has been a phenomenon across cultures and throughout history. However, it has recently become a more prominent issue for health care providers due to increased public awareness of the impact of human milk on an infant's long-term health and well-being, together with the increased connectivity available to individuals through social media.

While it is not the role of health care providers to promote informal milk sharing, in order to help parents make an informed decision, they must be able to discuss evidence-based information on the risks and benefits of all infant feeding options, including the use of unpasteurized donor milk. Perinatal Services BC has been developing a practice resource for health care providers to enable them to help parents make an informed decision. The resource is expected to launch in summer 2016.

Tea & Talk

We continue to host Tea & Talk video sessions via Telehealth to share information about our initiatives with provincial partners.

In 2015/16, we held presentations on the Aboriginal Pregnancy Passport, PSBC website redesign, and new resources for analysts. We tweeted live during these sessions using the hashtag #perinatalchat.

Registry, Surveillance, Performance & Analytics

The mandate of Perinatal Services BC is directly supported by the operation and maintenance of the BC Perinatal Data Registry (PDR). Data from the PDR are widely used for surveillance and research purposes and support health care providers, researchers, and policy makers in their work to improve maternal, fetal, and neonatal health outcomes and enhance the delivery and quality of perinatal services in BC.

Publicly Reported Facility-Level Indicators

In November 2015, Perinatal Services BC updated five facility-level maternal and neonatal indicators available on our website to include data for the 2013/14 fiscal year. Subsequently, PSBC prepared for the 2014/15 data update in the spring 2016 to be published in May 2016. This change in timeline from fall to spring enables stakeholders to access the data in a timelier manner.

We also added a sixth indicator with the 2014/15 data release that presents vaginal delivery rates for a lower risk group of women. This indicator may be used to monitor, support, and promote initiatives in normalizing births in BC.

The six indicators are:

1. Vaginal delivery for first-time mothers;
2. Early repeat cesarean delivery;
3. Post-date inductions done early;
4. Only intermittent auscultation in low-risk deliveries;
5. Healthy babies fed only breast milk; and
6. Vaginal delivery for eligible first-time mothers.

Specific definitions of the indicators are available on the website.

PSBC worked with a team of data consultants (Engage Data) to refresh and improve the data presentation of the facility-level indicators on the website. The new version includes three data views, multiple graphs, and interactivity that enables health authority and facility comparisons.

Giving Birth in BC

We also worked with Engage Data to develop a new section on the website for the public called *Giving Birth in BC*, which is an interactive exploration of perinatal data in BC. Viewers can get a snapshot of the health landscape in BC and how birth is changing with respect to the age of mothers, home births, and health care providers.

PDR Analytics Training

We developed a Level 1 analytics training package for health authority and hospital staff who use data from the PDR. The training package is a self-learning tool and includes exercises that are designed to assist staff in generating accurate and reliable information. Level 2 will be developed in 2016.

Mothers and Babies

43,805 mothers

46% first-time mothers

33% cesarean deliveries

51% by obstetrician

33% by family physician

14% by midwife

44,572 babies

11% preterm

3% multiples

Most recent data available is from 2014/15.

Published Articles

Frosst G, Hutcheon J, Joseph KS, Kinniburgh B, Johnson C, Lee L. Validating the British Columbia Perinatal Data Registry: A Chart Re-abstraction Study. *BMC Pregnancy & Childbirth*. 2015;15:123. DOI: 10.1186/s12884-015-0563-7.

Hutcheon JA, Lee L, Joseph KS, Kinniburgh B, Cundiff G. Feasibility of Implementing a Standardized Clinical Performance Indicator to Evaluate the Quality of Obstetrical Care in British Columbia. *Matern Child Health J.* 2015;19(12):2688-97. DOI: 10.1007/s10995-015-1791-1.

Joseph KS, Kinniburgh B, Hutcheon JA, Mehrabadi A, Dahlgren L, Basso M, Davies C, Lee L. Rationalizing Definitions and Procedures for Optimizing Clinical Care and Public Health in Fetal Death and Stillbirth. *Obstet Gynecol.* 2015;125(4):784-788. DOI: 10.1097/AOG.0000000000000717.

Joseph KS, Kinniburgh B, Metcalfe A, Razaz N, Sabr Y, Lisonkova S. Temporal Trends in Ankyloglossia and Frenotomy in British Columbia, Canada, 2004-2013: A Population-based Study. *CMAJ OPEN.* 2016;4(1):E33-40. DOI: 10.9778/cmajo.20150063.

Communications & Engagement

Perinatal Services BC continues to enhance communications, information sharing, and relationships with internal and external stakeholders. As new priorities and program areas are identified, we will incorporate them into our annual communications strategic planning.

Website

In September 2015, Perinatal Services BC completed the platform migration from Microsoft Content Management System to Sharepoint 2013. We continue to make improvements to content and navigation. One example is the Indicators Index to help users navigate through multiple maternal and neonatal indicators in various reports. The index includes a summary of pregnancy, labour, delivery, and newborn indicators with links to the relevant report sections on the website. Another example is the addition of a Health Alerts page to keep health professionals updated on emergent issues affecting pregnant women and newborns, such as the Zika virus.

Social Media

We continue to use our Twitter account (@PerinatalBC) to share perinatal information with stakeholders outside our regular health authority networks. We have increased our use of hashtags such as #perinatalchat for Tea & Talk sessions and #ruralmaternity for sustaining rural maternity and surgical services in BC. As of March 31, 2016, PSBC had over 600 followers.

In October 2015, during Breastfeeding Week, Perinatal Services BC co-hosted a tweet chat with Toronto East General Hospital and the Provincial Council for Maternal and Child Health in Ontario to talk about the importance of implementing the Baby-Friendly Initiative and how best to support breastfeeding mothers. The chat was presented by the Baby-Friendly Initiative Strategy Ontario, and the group hopes to host similar events in the future, engaging stakeholders from across Canada.

In 2015/16, PSBC tweeted live from four events, including our two-day *Healthy Mothers and Healthy Babies* conference in March 2016, which generated over 400 tweets and retweets using the conference hashtag #HMHBBC.

Appendices

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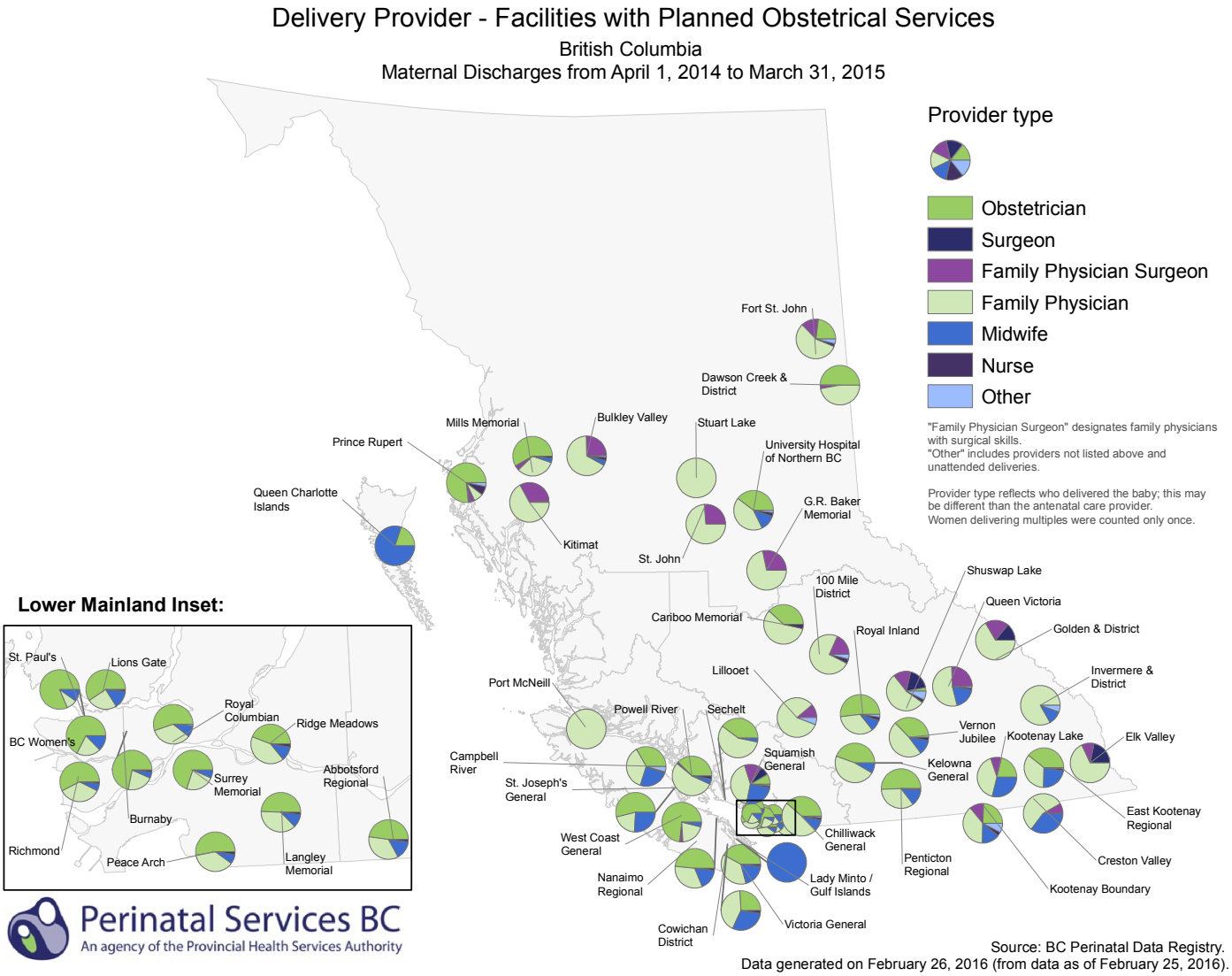
Appendix 1
Delivery Provider Map



Appendix 2
Indicators Report

SURVEILLANCE PERINATAL INDICATORS: QUARTERLY REPORT

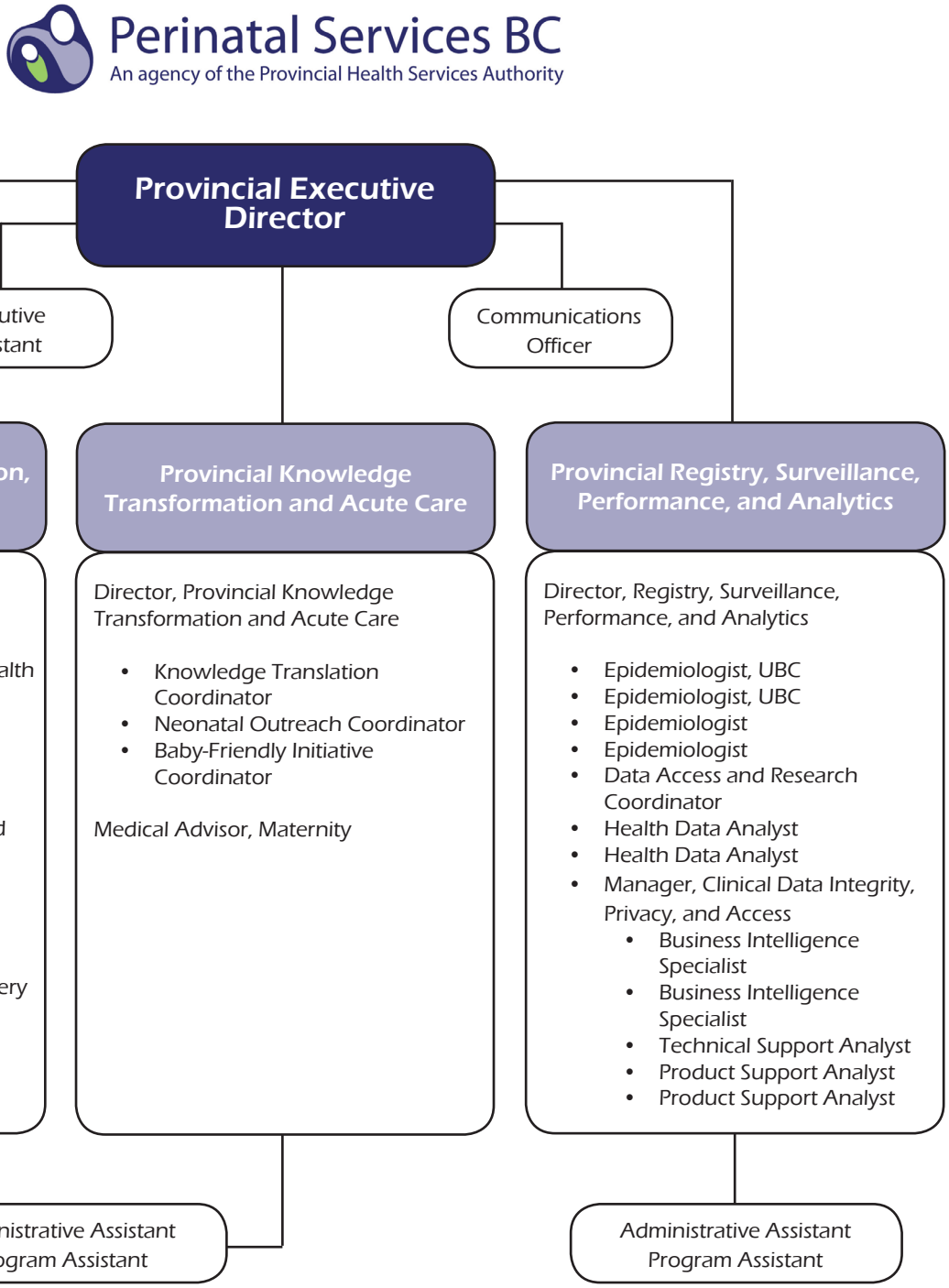
Indicator	2010/11 YTD	2011/12 YTD	2012/13 YTD	2013/14 YTD	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2014/15 YTD	2015/16* Q1	2015/16* Q2	2015/16* Q3	2015/16* YTD
Deliveries (Mothers): Number	**43,360**	**43,595**	**43,906**	**43,148**	**10,984**	**11,546**	**10,739**	**10,394**	**43,663**	**10,663**	**11,150**	**10,148**	**31,961**
Labour Induction (rate per 100 deliveries)	21.4	21.2	20.4	21.2	21.2	21.0	21.4	21.8	21.3	22.4	23.4	23.9	23.2
Cesarean Delivery (rate per 100 deliveries)	30.7	30.9	31.2	31.5	32.5	31.5	32.0	32.8	32.2	32.8	33.1	33.4	33.1
Pre-Pregnancy Body Mass Index Category (rate per 100 mothers with known BMI)													
Underweight	5.5	5.7	6.1	5.7	5.7	6.2	6.2	5.8	6.0	5.5	6.0	5.3	5.6
Normal	60.1	60.1	60.5	60.0	60.6	61.0	59.9	60.1	60.4	58.6	58.8	59.7	59.0
Overweight	21.1	21.2	20.1	20.7	20.7	19.8	21.1	20.5	20.5	21.3	20.8	21.0	21.0
Obese	13.3	12.9	13.0	13.7	13.1	12.9	12.8	13.7	13.1	14.6	14.4	14.0	14.4
Pre-Pregnancy Body Mass Index Unknown (rate per 100 mothers)	29.6	26.8	24.8	24.1	23.1	23.9	24.5	23.7	23.8	23.3	23.4	23.3	23.3
Maternal Transfers to Higher Level of Care Following Delivery[§] (rate per 1,000 deliveries)	5.1	5.7	5.2	5.9	6.1	7.4	8.7	8.1	7.5	8.0	7.8	8.7	8.1
Births (Babies)[†]: Number	**44,049**	**44,340**	**44,633**	**43,892**	**11,175**	**11,753**	**10,928**	**10,569**	**44,425**	**10,846**	**11,344**	**10,324**	**32,514**
Stillbirth Rate (rate per 1,000 total births)	10.3	9.8	9.4	10.5	12.3	11.1	10.2	11.5	11.3	10.5	10.3	11.5	10.8
Antepartum	8.2	8.1	7.9	9.2	11.0	9.7	9.2	9.3	9.8	8.9	8.8	10.7	9.5
Intrapartum	0.6	0.6	0.5	0.4	0.4	0.4	0.5	0.4	0.5	0.8	0.9	0.3	0.7
Unknown	1.5	1.1	1.0	0.8	1.0	0.9	0.5	1.9	1.1	0.8	0.6	0.6	0.7
Live Births by Gestational Age, Weeks (%)[¶]													
<34	2.3	2.4	2.4	2.4	2.4	2.3	2.6	2.4	2.4	2.4	2.5	2.2	2.4
34-36	7.1	7.2	7.6	7.7	8.2	7.4	7.5	8.2	7.8	7.9	7.9	9.0	8.2
37-40	79.6	80.1	80.2	80.6	80.3	81.2	80.6	80.8	80.7	81.2	81.0	81.0	81.0
41+	11.0	10.3	9.7	9.3	9.2	9.1	9.2	8.6	9.0	8.5	8.6	7.9	8.3
Unknown	0.03	0.04	0.01	0.02	0.01	0.01	0.00	0.02	0.01	0.04	0.06	0.03	0.04
Preterm Neonatal Intensive Care Use ₸ (rate per 1,000 live births)	38.0	34.2	35.7	35.0	37.8	34.1	37.7	38.0	36.8	37.4	38.7	39.2	38.6
>2 days	29.8	25.5	25.6	21.0	30.0	25.3	30.0	29.1	28.5	29.4	30.7	29.4	30.0
Sepsis	1.6	1.0	1.4	1.7	2.0	2.3	1.8	1.8	2.0	2.2	2.1	2.0	2.1
Ventilatory Support	7.7	6.8	6.7	7.4	7.2	6.3	7.6	5.9	6.7	7.3	6.5	5.8	6.5
Term Neonatal Intensive Care Use ₸ (rate per 1,000 live births)	34.4	23.1	24.6	26.7	30.6	29.5	28.2	32.3	30.1	35.6	34.4	30.6	33.6
>2 days	9.8	6.3	6.1	8.0	11.4	11.5	11.7	12.8	11.9	14.3	15.3	12.6	13.8
Sepsis	0.9	0.6	0.3	1.1	0.7	1.0	0.9	1.5	1.0	0.9	0.7	0.7	0.8
Ventilatory Support	2.1	1.9	2.4	2.4	3.0	2.8	2.0	2.9	2.7	3.3	3.7	2.2	3.0
Term Infants Receiving Exclusive Breast Milk During Birth Admission (rate per 100 live term births)	71.5	72.7	72.3	73.0	73.3	74.4	72.0	71.8	72.9	73.3	73.6	72.4	73.1
Neonatal Transfers to Higher Level of Care Following Birth (rate per 1,000 live births)	10.5	11.4	11.2	11.2	11.1	13.5	13.6	15.7	13.5	14.0	12.6	13.8	13.4
Neonatal Deaths (rate per 1,000 live births)	2.7	3.0	2.8	2.7	2.8	3.2	2.3	1.8	2.5	2.4	2.9	1.9	2.6

Data Source: BC Perinatal Data Registry

*Data for 2015/16 are preliminary.

Report Data Generated: May 20, 2016

Appendix 3
Organizational Chart



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