PSBC’s 2nd Biennial Conference

Advances in Clinical Practice & Research Across the Continuum

March 11-12, 2016  Vancouver, B.C.

Syllabus

presented by

Healthy Mothers & Healthy Babies

Perinatal Services BC
An agency of the Provincial Health Services Authority

Interprofessional Continuing Education
Healthy Mothers and Healthy Babies: Advances in Clinical Practice & Research Across the Continuum
MARCH 11 – 12, 2016    VANCOUVER, BC

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Conference Description & Objectives

This conference is hosted by Perinatal Services BC, an agency of the Provincial Health Services Authority. It is an opportunity for health care professionals interested in the care of pregnant and postpartum women and their newborns to be updated on new research and clinical best practices across the continuum of perinatal and newborn care. This conference will engage health care professionals from a wide range of disciplines in knowledge transfer and interprofessional collaboration in order to provide the best care possible and ensure healthy mothers and babies. The format will include plenaries, breakout sessions, poster sessions, and networking opportunities.

As a result of attending this conference, participants will be able to:

1. Review clinical best practices and new research acquired from researchers, experts, and fellow participants, which will inform the care of pregnant and postpartum women and newborns;
2. Reflect on five new developments across the continuum of care from conception to postpartum that will impact clinical practice;
3. Discuss current surveillance and system improvements in perinatal services that are relevant to improving maternal/fetal and newborn outcomes; and
4. Integrate knowledge learned by engaging in dialogue with other health care professionals from a range of disciplines

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Janet Walker  
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Leanne Yeates

Acknowledgements

Printing Support:

RR DONNELLEY
Exhibitor Listing

BC Cancer Agency

BC Lactation Consultants Association
Information on membership with BCLCA. This is a provincial society with the mandate to provide education and support for lactation consultants.

Canadian Agency for Drugs and Technologies in Health (CADTH)
CADTH delivers evidence, analysis, advice, and recommendations to health care decision-makers so that they can make informed decisions. Our approach is customer-focused and our products and services are designed to meet a broad spectrum of needs. Take a look and see if one of our products or services is right for you.

College of Midwives of British Columbia
The College of Midwives of BC regulates the midwifery profession under BC’s Midwives Regulation and Health Professions Act in the public interest. We register qualified, competent midwives to provide safe, high quality midwifery care to women and their families.

First Nations Health Authority - Early Childhood Development

FNHA Early Childhood Education and Maternal Child Health

Fraser Health Authority
Fraser Health is one of Canada’s largest and fastest growing health authorities, with over 24,000 employees, 2,500 physicians and nearly 6,500 volunteers.

GE Healthcare
Used in the birth of more than 45 million babies, Centricity Perinatal helps you deliver your best care to every mother and baby. With easy access to an unprecedented depth of patient information and improved transparency between providers, you’ll spend less time documenting so you can focus more on the people who count. Learn more at www.gehealthcare.ca/HCIT

Health Canada
The Environmental Program at Health Canada will provide information on Chemicals and Your Health, the HazardCheck Guide, Air Quality, Radon, Food, Nutrition and Food Safety.

Optimal Birth BC
Optimal Birth BC is a team of clinical practitioners and researchers who work with health authorities in BC to critically review rates of cesarean birth and associated patient and practice-related factors.

ODIN Books
Books and related resources, Gabor Mate Books.

Perinatal Services BC
Perinatal Services BC (PSBC) provides leadership, support, and coordination for the strategic planning of perinatal services in British Columbia and is the central source in the province for evidence-based perinatal information.

Western Canadian Association for Infant Mental Health
Networking with infant mental health professionals for collaborative workshops, giving information about World Association for Infant Mental Health, creating awareness of attachment-based interventions and training.
Presenter Listing

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# Conference at a Glance

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<tbody>
<tr>
<td>7:00 am</td>
<td>Registration and Breakfast</td>
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<tr>
<td>8:30 am</td>
<td>Traditional Welcome and Opening Remarks</td>
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<td>9:00 am</td>
<td>Plenary by Darci Lang</td>
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<td>10:00 am</td>
<td>Break</td>
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**Pinnacle Ballroom I**
- **A1i** The Impact of Maternal Weight and Gestational Weight Gain on Birth Weight
- **A1ii** The 5 A’s of Healthy Pregnancy Weight Gain: A New Tool and Training for BC’s Primary Care Providers
- **A1iii** College of Midwives – Quality Assurance Program

**Pinnacle Ballroom II**
- **A2i** TEEM Second Stage Labour Management: A Collaborative Strategy for Change
- **A2ii** Healthy Mothers Healthy Babies: Bridging the Gap in Perinatal Care for Women with Spinal Cord Injury
- **A2iii** Birth After Cesarean: How Do Women Make Decisions about Mode of Delivery?

**Dundrave**
- **A3i** Low Risk Birth Quality Based Procedure in Ontario
- **A3ii** Re-building Maternity Services: Dangerous Ideas from the Hinterland
- **A3iii** Building a Maternity Care Network in Urban Family Practice

**Pinnacle Ballroom III**
- **A4i** The BC Healthy Connections Project: A Scientific Evaluation of Nurse-Family
- **A4ii** Healthy Babies Healthy Children Screen Validation
- **A4iii** Trends in Domperidone Use Postpartum and Its Association with Ventricular Arrhythmia

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<td>Lunch</td>
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<td>Poster Session</td>
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- **B1iii** Inadequate Prenatal Care Use and Breastfeeding Practices in Canada: A National Survey of Mothers

**Pinnacle Ballroom II**
- **B2i** Gestational Diabetes in South Asian and Chinese Women in BC & Alberta
- **B2ii** Best Practices for First Nations Women with Gestational Diabetes
- **B2iii** CPT1 Variant in First Nations Populations Resulting in Infant Hypoglycemia

**Dundrave**
- **B3i** Safety of Labour and Delivery Following Obstetrical Service Closures in Community Hospitals in British Columbia Canada
- **B3ii** The Art of the Possible: Interdisciplinary, Collaborative Primary Maternity Care in BC
- **B3iii** Apple Tree Maternity: A Qualitative Exploration of Rural Collaborative Interprofessional Maternity Care

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- **B4i** Seamless Perinatal Transition Team – The Move to Implementation
- **B4ii** Beyond Birth Classes: A New Model for Perinatal Education
- **B4iii** Postpartum Care in the Community: Universal and Enhanced Services

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<tr>
<td>3:00 pm</td>
<td>Break – Exhibits Open, Poster Viewing</td>
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<tr>
<td>3:30 pm</td>
<td>Plenary Session by Tamara Taggart</td>
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<tr>
<td>4:45 pm – 7:00 pm</td>
<td>Networking Reception</td>
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### Conference at a Glance

**Saturday, March 12**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>7:00 am</td>
<td>Breakfast</td>
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<tr>
<td>8:30 am</td>
<td>Normalizing Birth from Policy, Practice and Lived Experience Panel</td>
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<tr>
<td>10:00 am</td>
<td>Break – Exhibits Open, Poster Session</td>
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<tr>
<td>10:30 am</td>
<td>Concurrent Sessions C</td>
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#### Pinnacle Ballroom I
- **C1i** Supporting Both Breast Feeding and the Baby at Risk for Hypoglycemia
- **C1ii** Got Milk? Expansion of the BC Women’s Provincial Milk Bank
- **C1iii** Congenital Cytomegalovirus Infection: A New Era of Diagnosis and Treatment in BC

#### Pinnacle Ballroom II
- **C2i** A Historical and Medical Critique of Circumcision / Intact Babies: Avoiding Clinical Errors
- **C2ii** Creating Healthy Babies: Baby Brain Development, Nutrition, and Traditional Knowledge
- **C2iii** New Priorities and Advances in Well-Baby/Well-Child Care for Children 1 week to 5 years of age from the 2014 Rourke Baby Record

#### Pinnacle Ballroom III
- **C3i** The Physiological Effects of Immediate to Early Skin-to-Skin Contact on Mother and Newborn Transition: A Systematic Review
- **C3ii** MotherBaby Care... Supporting Mothers and Babies to Stay Together... One Couplet at a Time!
- **C3iii** Safety Culture Experiences of NICU Parents: A New Angle of Safety Intelligence

#### Dundrave
- **C4i** Old Need, New Technology: Providing Prenatal Support via Text-Message and Online-Only Group
- **C4ii** A Randomized Controlled Trial to Evaluate the Effect of Telephone-based Interpersonal Psychotherapy Provided by Nurses for the Treatment of Postpartum Depression
- **C4iii** Safe Sleep, Day and Night: Metro Vancouver Mothers’ Experiences Regarding Infant Sleep Safety

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<th>Time</th>
<th>Session</th>
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<tr>
<td>12:00 pm</td>
<td>Lunch – Exhibits Open, Poster Viewing</td>
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<td>1:00 pm</td>
<td>Concurrent Sessions D</td>
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#### Pinnacle Ballroom I
- **D1i** Screening for Postpartum Anxiety: Is the EPDS Enough?
- **D1ii** Trajectories of Perinatal Depressive and Anxiety Symptoms in a Community Cohort
- **D1iii** Immigrant Women’s Experience of Postpartum Depression in Canada: A Narrative Synthesis Systematic Review

#### Pinnacle Ballroom II
- **D2i** Changing Provincial Regulations – the Newborn Eye Prophylaxis Story
- **D2ii** Prevention of Congenital Syphilis in the Context of Rising Syphilis Diagnoses in BC
- **D2iii** Perinatal Hepatitis B Screening and Infection in British Columbia

#### Dundrave
- **D3i** “How Long Should I Wait?” A Panel Discussion Reviewing Current Evidence and Best Practice to Support Optimal Inter-pregnancy Intervals for Older Mothers
- **D3ii** Interpregnancy Intervals and Infant Outcomes: Does Matching Two Intervals in the same Mother Change the Associated Risks?
- **D3iii** The Experience of Women in Remote Carrier Communities with Bedside Ultrasound at Prenatal Visits: Preliminary Findings from a Community Engagement Project
- **D4i** Babies Born Behind Bars
- **D4ii** A Paradigm Shift: Island Health is Changing the Way Public Health Nursing Provides Care to Women and Families During Pregnancy and Parenting by Adopting the Nuu-chah-nulth Nursing Program’s Mother’s Story Approach to Care
- **D4iii** Harm Reduction and Pregnancy: Best and Promising Practices for Supporting Pregnant Women and New Mothers Who Use Substances

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<tr>
<th>Time</th>
<th>Session</th>
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<tr>
<td>2:30 pm</td>
<td>Break – Exhibits Open, Poster Viewing</td>
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<tr>
<td>3:00 pm</td>
<td>Plenary Session by Gabor Maté</td>
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<tr>
<td>4:30 pm – 5:00 pm</td>
<td>Closing Remarks &amp; Evaluation</td>
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Plenary  Focus on the 90%
Darci Lang
A1i  The Impact of Maternal Weight and Gestational Weight Gain on Birth Weight

Núria Chapinal

More than half of women in Canada gain excessive weight during pregnancy whereas approximately one fifth of women do not gain enough weight. Both excess and inadequate gestational weight gain significantly increase maternal and infant risks.

Based on data collected during the Canadian Maternity Experiences Survey from 2005-2006, excess gestational weight gain has more impact than pre-pregnancy weight on adverse outcomes such as large for gestational age infants. On the other hand, inadequate gestational age weight contribution exceeds that of prenatal smoking for preterm birth and small for gestational age infants. Hence, gestational weight gain is an important clinical and public health issue. Since survey data have some limitations (including volunteer bias and inaccuracies associated with self-reporting), further research using administrative data is needed.

Biography

Nuria Chapinal is an epidemiologist with Perinatal Services BC where she is responsible for conducting routine and special analyses. Some of her current projects include monitoring the uptake and predictive value of prenatal genetic screening, estimating the needs for neonatal NICU beds in BC, and studying the effect of pregnancy weight gain on birth weight.

Learning Objectives:

1. Describe the extent of excess and inadequate pre-pregnancy maternal weight and gestational weight gain in BC
2. Determine the impact of excess and inadequate pre-pregnancy maternal weight and gestational weight gain on birth weight.
More than two-thirds of women of childbearing age are overweight or obese, and these numbers have increased dramatically in the last few decades in Canada. Furthermore, average weight gain in pregnancy has increased over the last four decades from 10 to 15 kg and a significant number of women are exceeding pregnancy weight gain recommendations. Excessive weight gain in pregnancy has been identified as a modifiable risk factor for a range of important maternal, obstetric and child outcomes, including gestational diabetes, hypertension, caesarean delivery, fetal overgrowth, and downstream child obesity. The 5 As of Healthy Pregnancy Weight Gain is a new theory-driven, evidence-based minimal intervention designed to facilitate weight gain counselling and management by prenatal care providers. Developed by the Canadian Obesity Network with input from experts across the country, including BC, this new practice support resource includes a practitioners guide, checklist and patient resource. Perinatal Services BC, with input from care providers across the province (including GPs, Registered Midwives, Nurse Practitioners, Obstetricians, and Dietitians), has led the development of a provincial training plan on the 5 As of Healthy Pregnancy Weight Gain. An accredited online training module has been developed with UBC Faculty of Medicine’s Continuing Professional Development, as well as a series of in-person regional trainings across the province.

Biographies

Adam is responsible for leading the development and implementation of best practice initiatives which promote healthy pregnancies and healthy infants in collaboration with other agency leaders, the Ministry of Health, and provincial stakeholders, including frontline leaders in community, primary care, and acute care settings as well as the public. He is also responsible for building quality health promotion knowledge and skills across the health care continuum and assisting to prioritize health promotion issues and developing evidence-based solutions. Adam has a Master of Public Health and has previously led maternal-child health promotion initiatives at the international level through UNICEF and the Aga Khan Foundation; at the federal and provincial levels through the Public Health Agency of Canada; and at the regional level through Fraser Health. Adam maintains a deep interest in global health systems and has consulting experience in Tanzania, China, Russia, Syria, Bangladesh, and Sri Lanka.

Christina is a family physician and a specialist in Public Health and Preventive Medicine and has a Master of Science in Reproductive and Sexual Health Research. She has practiced medicine in urban and rural BC and the Northwest Territories. She is a clinical instructor at the School of Population and Public Health at the University of British Columbia and provides maternity care at BC Women’s Hospital. In her role at PSBC as Primary Maternity Care Lead – Family Physician, Christina works closely with PSBC’s Primary Maternity Care Lead – Midwifery to support primary maternity care and promote interdisciplinary collaborative practice. They provide ongoing clinical consultation on initiatives that impact primary maternity care, including data collection and analysis, guideline development, knowledge translation, and system planning. Christina is also the clinical link between PSBC and family physicians across BC

Learning Objectives

By the end of the presentation, participants will be able to:

1. Highlight the importance of healthy pregnancy weight gain on a range of maternal, obstetric and child outcomes.
2. Describe Health Canada/Institute of Medicine’s guidelines on gestational weight gain.
3. Understand how the 5As framework to help facilitate gestational weight gain counselling and management in a primary care practice.
4. Identify how you can participate in training opportunities on the 5As for Healthy Pregnancy Weight Gain.
College of Midwives – Quality Assurance Program
Doris Chan

Author
Joanne Daviau
Quality Assurance and Clinical Practice Policy Director
CMBC

Abstract
The College of Midwives of BC (CMBC) is in the process of rolling out a Quality Assurance Program including a random practice review in anticipation of the enactment of section 26.1 of the Health Professions Act. This presentation will look at the steps the College has taken to create the program including reviewing best practices at other health professional colleges, surveying members, and the program's evolution.

Based on these initial steps, the presentation will explore the work to date, the formation of the Quality Assurance Program, and its constant refinements and improvements. Questions will be addressed during the presentation such as: What will the QA Program cover? How will a random practice review be done? Would it be perceived as a punitive process? Will the reviews identify issues that require further investigation? Why is the College doing this? Samples of mini reviews will be discussed as well as a walkthrough of what a full site review would look like from the initial notification until the completion of the process. Checklists to prepare for the reviews will be available. The CMBC is committed to ensuring that the Quality Assurance Program is open, transparent, relevant, and a learning opportunity for both the midwives and the regulators. This will ensure the program is respected and helps inform practices of midwives and the standards of the regulator. The end goal of this presentation is to communicate with midwives and other health professionals about the Quality Assurance Program and to receive feedback.

Biographies
Doris Chan is the Deputy Registrar and Director of Finance with the College of Midwives of BC and has assumed this role since 2008. The College of Midwives regulates the midwifery profession under the BC’s Health Professions Act and the Midwives Regulation, and is dedicated to ensuring women and their families receive a high standard of midwifery care that includes continuity and informed choice.

In her role with the College of Midwives, Doris is involved in the strategic and organizational planning and implementation for carrying out the duties set out in the Health Professions Act and the College Bylaws. She is responsible for overseeing matters related to registration and inquiries and discipline, and involved in projects related to quality assurance and standards of practice. She also has specific responsibility for the overall financial management of the College and is responsible for performing the duties of the Registrar in her absence.

Prior to joining the College of Midwives, Doris was the Deputy Registrar with the College of Dental Technicians of BC, another regulatory college governing the profession of dental technician. With the two positions, Doris has over 15 years of experience in working in BC colleges regulating health professionals and is highly committed to professional self-regulation and governing the practice of health professionals in the public interest.

Doris has a Bachelor of Technology in Accounting. She received her certified general accountant designation in 2009 and is currently a Chartered Professional Accountant.

Learning Objectives
1. Learn about the Quality Assurance Program that is being delivered by the CMBC in terms of its purpose, timing, and execution.
2. Midwives will learn how to prepare for a review and what to expect from a review. The College welcomes feedback on ensuring the process is relevant.
TEEM Second Stage Labour Management: A Collaborative Strategy for Change

Cynthia Mann

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Intrapartum, Home Birth Second Attendant
Dalhousie University School of Nursing,
Department of Obstetrics & Gynaecology Dalhousie
University/IWK Health Centre

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Women’s and Newborn Program
IWK Health Centre

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Author #7
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Author #8
Hilary Kinnear MD
Family Physician
IWK Health Centre

Author #9
Jessie Harold
Volunteer Doula Program
Chebucto Family Resource Centre

Author #10
Christine Richey
Mother

Abstract

Background: Management of the second stage of labour (from full dilatation to delivery of the newborn) is fraught with inconsistencies in both practice and in outcomes for mother and infant. The purpose of this developmental project was to garner an understanding of the context in which second stage is managed, as well as, the barriers and the enablers that influence the implementation of second stage clinical practice guidelines (CPGs).

Methods: Participants (Nurses, Midwives, Obstetricians, OBS Residents, Anesthetists, & Family Doctors) attended audio recorded interviews or focus groups. Transcripts were independently coded and grouped. The PARIHS Framework4 and the Theoretical Domains Framework2 guided our understanding of provider behavior. We used directed content analysis to enhance an understanding of both best strategies and interventions for the implementation of second stage CPGs.

Results: We identified several barriers and facilitators for the implementation of CPGs during our preliminary analysis. Barriers were grouped into four themes; style, technology, context, and continuity of care. Facilitators were grouped into three themes; support, evidence, and education.

Conclusion: The findings from this study set the stage to identify effective strategies for implementing second stage CPGs. Implementation of an evidence-based second stage management CPG will enable health care providers to collaborate and improve second stage management thereby promoting healthy birth experiences for mothers and newborns.

Learning Objectives

1. List three context characteristics that influence the implementation of evidence in clinical practice
2. Discuss barriers and enablers that influence the implementation of a second stage management CPG
Healthy Mothers and Healthy Babies: Bridging the Gap in Perinatal Care for Women with Spinal Cord Injury
Melanie Basso, Karen Hodge

Abstract
Background: A multidisciplinary team of nurses, physicians, and researchers as well as a consumer have worked together to explore issues around reproductive health for women with spinal cord injury. We understand that following to be the key issues:

- Lack of coordinated and reliable information for women with spinal cord injury who are interested in exploring options for pregnancy
- Varied and inconsistent response from health care professionals who provide pregnancy care
- Lack of clear coordination between health team members with expertise in spinal cord injury care and those who provide pregnancy care
- Lack of clarity about key barriers and gaps in knowledge about pregnancy and spinal cord injury
- Lack of research evidence available to guide care

Current Practices
Currently there is a need to develop resources for women with spinal cord injury who are contemplating pregnancy, as well as a need for resources for care providers to guide them.

Results: Our multidisciplinary team has worked together to develop a consumer booklet and brochure. We have submitted web-based content on pregnancy and SCI to the SOGC for their consumer focused website. We have developed a video, available on YouTube, which documents the Journey to Motherhood by our consumer, Karen Hodge.

Implications for Practice: We are currently involved in research to explore the lactation and breastfeeding experience of women with SCI. Attendees of this session are guided through putting best evidence into practice through exposure to care in four stages of perinatal care: Preconception, Antepartum, Intrapartum, and Postpartum (Going Home).

Biographies
Melanie Basso is the Senior Practice Leader for BC Women’s Hospital, involved in advanced planning for women with complex pregnancies. Shea Hocaloski is a Sexual Health Clinician, assisting patients to regain sexual function following spinal cord injury. Stacey Elliott is a Clinical Professor in the Department of Psychiatry and Urologic Sciences.

Karen Hodge is a woman with spinal cord injury and mother of two young children.
Learning Objectives

1. Understand the process used to identify gaps in perinatal services for women with spinal cord injury
2. Display the tools/resources developed to address these gaps
3. Describe the research being conducted to understand the experience of lactation for women with spinal cord injury
4. Be able to apply new knowledge to future clinical experiences with women with spinal cord injury
Abstract

Background/Rationale: Best evidence indicates that over 80% of women with a previous caesarean should be offered a planned vaginal birth after caesarean (VBAC), however only one third of women plan a VBAC. To address this critical knowledge-to-action gap, we explored the question, What are women’s attitudes toward and experiences with decision-making for birth after caesarean in British Columbia?

Methods: In-depth, semi-structured interviews were conducted with women eligible for VBAC, recruited from two communities in Fraser Health and three communities in Northern Health. Sites were selected purposively to represent the range of maternity services in BC, based on rate of actual VBAC, level of service, rurality, and population vulnerability. Constructionist grounded theory guided the iterative data collection and analysis.

Results: Analysis of interviews (n=23) revealed that women make a choice about preferred mode of delivery after caesarean during their inter-pregnancy interval, typically without input from a healthcare professional. Women’s choices were informed by their first birth experience, birth stories from peers, and online information. Women received unclear and often contradictory information from care providers about the risks and benefits of VBAC versus repeat caesarean. Few received information from their care provider on the attributes of the decision that mattered most to them.

Conclusions: Women’s preferences for birth after caesarean begin after their primary caesarean. Interventions to support informed decision-making may begin in the immediate postpartum after the woman’s primary caesarean and may include debriefing about her birth as well as a patient decision aid based on best evidence.

Biographies

Sarah Munro is a PhD Candidate in Interdisciplinary Studies at the University of British Columbia, supervised by Dr. Patti Janssen (School of Population and Public Health) and Dr. Jude Kornelsen (Department of Family Practice). Her research intersects maternity care, health services, and knowledge translation (KT) research. She is interested in developing and evaluating shared decision-making interventions. Her PhD research explores KT methods to enhance decision-making for vaginal birth after caesarean (VBAC).

Learning Objectives

1. Understand women’s attitudes toward and experiences of decision-making for birth after caesarean in British Columbia
2. Learn about the role of debriefing and patient decision aids to support informed shared decision-making
Abstract

The Provincial Council for Maternal and Child Health (PCMCH) is currently undertaking two interconnected initiatives related to low risk maternal newborn care. Together, these initiatives will help to promote safe vaginal birth in low-risk women and increase equitable access to low risk maternal newborn care no matter where a woman resides in the province.

The Low Risk Birth Quality Based Procedure (QBP) was mandated as part of the Ontario Ministry of Health and Long Term Care’s Health System Funding Reform. The ministry tasked PCMCH to work closely with clinical leaders to publish a clinical handbook to support effective and efficient patient care management for low risk births in Ontario. Adoption of best practices will allow health service providers and hospitals that deliver obstetrical care to review their internal processes and engage in clinical process design, as deemed appropriate, to promote safe vaginal birth in low risk women, reduce caesarean section rate variation across the province and most importantly, improve patients’ experience and outcomes.

The Low Risk Maternal Newborn Strategy was also mandated by the Ontario Ministry of Health and Long Term Care to respond to access, quality and sustainability challenges in low risk maternal newborn services. In the spirit of collaboration and system leadership, PCMCH convened a group of dedicated professionals to lead the development of this provincial strategy. The Low Risk Maternal Newborn Leadership Team and Expert Panel comprise of leaders in maternal-newborn care, ranging from midwifery, family medicine, nursing and obstetrics from across Ontario.

The province has an exciting opportunity to design a woman- and family-centred low risk strategy that ensures equitable access to care as close to home as possible and allows women and their families to make informed decisions about the type of care they wish to receive, no matter where they live in the province.

Biographies

James is the Executive Director for the Provincial Council for Maternal and Child Health – a provincial program with the Ontario health care system that is dedicated to improving the maternal, child and youth health system. The Council is a provincial forum where leaders identify opportunities for improvement, create consensus on standards and practices that will improve patient care, and provide advice to the Ministry of Health and Long-Term Care, system planners and health care providers on ways to advance the maternal and paediatric health system.

A known change leader, James came to PCMCH in February 2015 from the Central East Local Health Integration Network (Central East LHIN) where he was the Senior Director, System Design and Implementation since 2006. Prior to the LHIN, James was a senior policy advisory in the Ministry of Health and Long-Term Care. In these positions he held direct responsibility for Strategic Planning, Health Services Integration and Implementation, Quality Improvement, Community Engagement and Change Management, Decision Support, and Performance
Management and Evaluation.

In all of his work, James works with partners to achieve the Triple Aim – the simultaneous improvement in patient experience, population health, and cost control. A proponent of a “systems of care” approach, James seeks to connect patients, families, front-line providers and system managers to develop and implement integrated solutions that will achieve better experience, better health and better value.

Born and raised in Ontario, James has undergraduate and graduate degrees in political science and philosophy from Carleton University (Ottawa) and The Catholic University of America in (Washington DC). He is also a graduate of the Rotman School of Business Leadership Program.

When not in the office or with family, James can be found cycling the beautiful roads of Ontario.

Preeti is a Senior Project Manager at the Provincial Council for Maternal and Child Health. She has been with PCMCH for two years with a primary focus on maternal-newborn care.

**Learning Objectives**

1. Showcase efforts in Ontario to develop an interconnected strategy for low risk maternal newborn care and share lessons learned that could be applied in other jurisdictions.
Abstract

Background and Rationale: Key characteristics of rural maternity care – low volume, low resources and geographic and professional isolation – are often posited as contributing to the lack of sustainability of these services. We can, however, turn these assumptions around and recognize the resilient capacity of rural health teams. Viewed this way, instead of lack of sustainability the output may be innovation.

Learning Objectives: We will suggest and review three key learnings we have gleaned from rural maternity research and realist reviews, learnings that can inform planning for all maternity services. These ‘dangerous ideas’ start with evidence-based indications for planning appropriate levels of services based on community attributes and population need. Following, primary and secondary evidence on the safety of rural services without immediate access to cesarean section will be considered alongside evidence on appropriate models of care for First Nations communities. Finally, we will review the importance of a generalist approach to providing rural maternity care through evidence on the safety of cesarean section services attended by General Physicians with Enhanced Surgical Skills.

Methods: Results from primary research in rural British Columbia and findings from realist reviews will be considered from the perspective of patient outcomes, sustainability and satisfaction from within the framework of a ‘networked model’.

Results and Conclusions: Considering solutions to the challenges of low volume and isolation in maternity services within a framework of patient outcomes, sustainability and satisfaction will lead to directions for health planning that may be applied to the larger system.

Biographies

Dr. Jude Kornelsen is an Associate Professor in the Department of Family Practice at the University of British Columbia, Co-Director of the Centre for Rural Health Research, Director of the Applied Policy Research Unit (APRU), and Honorary Associate Professor in the Medical School, Sydney University, Australia. Her primary research focus is on rural health issues, particularly the investigation of appropriate levels and models of maternity care for rural communities.

Dr. Stefan Grzybowski is a family physician researcher and professor in the Department of Family Practice, UBC. He has been a MSFHR Senior Scholar; is co-director of the Centre for Rural Health Research, and is the director of the Rural Health Services Research Network of British Columbia. His current research is focused on the study of rural maternity care and small rural surgical services in BC with the goal of improving health services for rural communities.

Learning Objectives

1. Understand evidence-based indications for appropriate levels of service in rural communities;
2. Understand synthesized evidence on the safety of rural services without immediate access to cesarean section
3. Understand models of care for First Nations communities
4. Understand evidence on the safety of cesarean section services attended by General Physicians with Enhanced Surgical Skills
Abstract

Background/Rationale: Urban family physicians’ (FPs) role in maternity care has reduced due to increasing complexity of obstetrical care, difficulty balancing office/hospital practice, and insufficient caseload to maintain competency. The Vancouver Division of Family Practice (VDoFP) has identified maternity care as a priority area, given that all FPs provide care to pregnant women, whether or not they attend births.

Methods: Workshop series was developed by VDoFP and UBC CPD. Presentations cover best practices in maternity care; case examples and resources facilitate knowledge application. Discussions facilitated by FPs providing full spectrum maternity care maximize mentorship, network building, and referral opportunities. Individual data on prenatal genetic screening and evidence-based quality improvement coaching sessions from the Practice Support Program (PSP) serve as tools for practice change. Pre/post surveys and written reflections capture impact of workshop.

Results: 328 participants attended seven workshops. Participants’ comfort in providing maternity care increased significantly from before (M=4.36/7, SD=1.55) to after workshops (M=5.11/7, SD=1.37); t(387)=5.34, p<0.001. Connectedness to FPs who provide full spectrum maternity care increased significantly from before (M=3.71/7, SD=1.79) to after workshops (M=4.83/7, SD=1.53); t(393)=7.13, p<0.001. Of 258 participants offered coaching sessions, 59 (23%) participated. Impact on maternity care provision includes more systematic visits through higher efficiency workflow, greater resource awareness, timely investigations, and improved referral networks.

Conclusions: Workshops addressed a perceived need within urban practice. This novel approach of collaboration between CPD providers, physician organizations, and the PSP to facilitate knowledge exchange, mentorship, quality improvement, and cultivation of a maternity care network is applicable to other contexts.

Biographies

Kaitlin holds both a BA in Women’s Studies and a Diploma in Intercultural Education from the University of Victoria, and a Masters of Arts degree in Women’s, Gender and Sexuality Studies from Simon Fraser University. She has six years of experience designing, implementing, and managing education and training programs. She is currently a Project Manager at UBC CPD leading multiple projects one of which is the Vancouver Division of Family Practice Collaborations.

Dr. Fernandez attended medical school and family practice residency at the University of British Columbia. Since that time, her practice has been focused on women’s health and maternity care. She also works with the Youth Pregnancy and Parenting program in Vancouver. She currently serves on the Board of Directors for the Vancouver...
Division of Family Practice. She is passionate about maternity care and the unique skills that family doctors bring to pregnancy and birth care.

**Learning Objectives**

1. Understand the innovative collaborative model used by CPD providers, physician organizations, and practice support programs to improve the quality of maternity care provided by FPs in Vancouver
2. Describe the model’s successes, challenges, and lessons learned in improving family physician participants’ quality of care for maternity patients
3. Become familiar with the role of CPD providers, physician organizations, and practice support programs in supporting family physicians to integrate practice change
The BC Healthy Connections Project: A Scientific Evaluation of Nurse-Family Partnership in British Columbia

Donna Jepsen, Nicole Catherine, Pamela Parkinson

Abstract

This presentation will update the registrants on the rigorous scientific methodology (randomized-controlled trial and process evaluation) of the BCHCP which began in 2013, to compare Nurse-Family Partnership (NFP) with existing services available for young women who are socioeconomically disadvantaged and parenting for the first time. NFP is an evidence-based intensive public health nursing home visitation program which begins in pregnancy and continues until the child turns age two. The context of reducing child maltreatment, improving child mental health and development, and improving maternal life course outcomes such as economic self-sufficiency will be explored. Central to the effectiveness of the NFP model, over 60 public health nurses have developed therapeutic relationships with over 500 clients across all 5 regional health authorities. It is anticipated that approximately 1000 women will enroll in the RCT by December 2016. Referral volumes of pregnant women through the health authority public health prenatal registries will be discussed.

The presentation will also discuss the process evaluation of NFP’s feasibility and acceptability with PHNs and supervisors in communities across BC. NFP PHNs and supervisors continue to be interviewed to help determine recommended program adaptations and enhancements needed to achieve positive outcomes in the BC context prior to any expansion of the program in BC or Canada.

Biographies

Donna Jepsen is a registered nurse and is the Provincial Coordinator of Nurse-Family Partnership in BC with the Ministry of Health. This role was created in January 2012 to help support the implementation of NFP in BC through the BC Healthy Connections Project. Donna has worked in public health in Northern Health and Vancouver Coastal Health where she held the position of a multi-disciplinary public health and prevention program leader. She has a BSN from UVIC, an MSC from the University of Alberta, and is a Certified Community Health Nurse in Canada.

Dr. Nicole Catherine is the Scientific Director of the BC Healthy Connections Project, Mowafaghian University Research Associate, and an Adjunct Professor in the Faculty of Health Sciences at Simon Fraser University. Dr. Catherine is an interdisciplinary researcher with doctoral and post-doctoral training in neurobiology, developmental psychology and public health and is an experienced leader in clinical and behavioral intervention trials.

Pamela Parkinson is a Maternal, Child, and Family Policy Analyst with the Ministry of Health. She holds a BSc from the University of Alberta, a MSc from UBC specializing in neuroscience, and has recently completed a MPH from SFU.

Learning Objectives

1. Review the rigorous scientific methodology of the BCHCP, including the randomized-controlled trial and process evaluation methods
2. Discuss how the process evaluation is contributing to identifying quality improvements that are necessary in the BC context prior to any full scale implementation of NFP in Canada
Abstract

Background/Rationale: Healthy Babies Healthy Children (HBHC) is an Ontario program designed to identify and support families with vulnerabilities that could compromise healthy child development. A component of the program is universal postpartum screening, which is meant to comprehensively identify risks to healthy child development. Prior to implementation of the HBHC Screen program wide in 2013, an evaluation of the Screen was conducted in order to assess its ability to correctly identify families with risk factors who would benefit from HBHC home visiting services and interventions.

Methods: For the purposes of validation, 12 public health units across Ontario administered the HBHC Screen with families in the postpartum period. In order to identify whether or not the HBHC Screen was accurately identifying risk, its outcomes were compared to the outcomes of the In-Depth Assessment, a more extensive tool that is used as a measure of true risk. Furthermore, three methods of administering the HBHC Screen were compared to assess whether modifying Screen administration affects its ability to identify risk.

Results/Conclusions: The results of the evaluation indicate that the HBHC Screen is a comprehensive tool for identifying vulnerable families across all three methods of administration, ensuring effective transition postpartum from hospital to community and into the HBHC program. The results also indicate the benefit of collaboration between hospitals and public health units in the screening process. Evaluation results provided insight into best practices for the identification of risk in families, and have been used to inform how the HBHC Screen is administered provincially.

Biographies

Sara Cave is a Research Analyst at the Ontario Ministry of Children and Youth Services, where she does research and data work for provincially delivered Healthy Child Development programs. She received her Master of Public Health from Queens University, where she discovered her interest in maternal and child health.

Learning Objectives

1. Demonstrate how the HBHC Screen effectively and efficiently identifies various bio-physical and psychosocial risks to healthy child development and supports targeted home visiting services to vulnerable families

2. Apply the American Academy of Pediatrics classification of an effective developmental screen to assess the HBHC Screen’s ability to identify risk, and inform provincial implementation

3. Explore how effective collaboration between hospitals and public health units in the screening process, can lead to partnership development and more accurate identification of risk in families
Abstract
Domperidone is a dopamine antagonist commonly used off-label to stimulate milk production in mothers who have low milk supply. In this population-based study of all women with a live birth between 2002 and 2011 in BC, we examined the nature of increasing postpartum domperidone use. We also examined the relationship between domperidone use and adverse health outcomes in the mothers.

Biography
Dr. Smolina is a postdoctoral fellow in pharmaceutical policy and pharmacoepidemiology at the Centre for Health Services and Policy Research at UBC. Her two streams of research are prescription drug use in pregnancy and use of opioid analgesics for chronic-non-cancer pain. Kate holds a BSc in Bio-Medical Science from the University of Guelph. She completed her PhD in Epidemiology at the University of Oxford on a Rhodes Scholarship. She received the CIHR Banting Postdoctoral Fellowship for her work at UBC.

Learning Objectives
1. Describe trends in domperidone use by BC women during postpartum
2. Discuss the association between domperidone and ventricular arrhythmia
Two Practice Concerns in BC: Safe Infant Sleep Recommendations and Policies Supporting Breastfeeding Exclusion and Duration. Improving Health while Reducing Costs

Rhoda Taylor, Tina Revai

Abstract
The BC Lactation Consultants Association (BCLCA) membership has identified as priority practice concerns two issues with major policy and practice implications across the province. One is the application of informed, shared decision making processes to recommendations for safe infant sleep practices. Despite the well-intended anti-bedsharing message in public health, most families continue to bedshare, at least some of the time. The second is the lack of consistent, effective support for breastfeeding duration and exclusive breastmilk feeding with the resultant significant short and long term cost penalty to the health care system in BC.

Two position papers were developed by the presenting authors. The conclusion of the papers are: it is the recommendation of BCLCA that (1) a collaborative working group be established to review the evidence and consider the perspective of the healthcare consumer in the development of safe infant sleep resources; and (2) that a provincial breastfeeding policy be established in BC which provides clear and specific evidence based goals, defined reporting standards, and target dates for implementation.

This talk will present the research upon which these conclusions and recommendations are based and encourage an open discussion.

Biographies
Tina Revai is a mother of one, an IBCLC since 2007 and a volunteer La Leche league Leader. She is currently in the Masters of Nursing program at the University of Victoria. Rhoda Taylor is a mother of 3, grandmother of 5, an IBCLC since 1987 with a background in resource management, economics and public health. They are passionate about supporting mothers in their journey of breastfeeding and working towards a system which supports all families in achieving their infant feeding goals.

Learning Objectives
1. Recognize the possible consequences of a variety of sleep arrangements
2. Understand the implications and importance of consumer participation in the development of an infant sleep decision making tool
3. Evaluate the importance of including substantive breastfeeding goals in the Ministry of Health Service Plan and the BC Framework for Public Health
4. Breastfeeding exclusivity and duration rates with both an economic and public health lens
B1ii Physicians’ Breastfeeding Toolkit: A New Collaborative Resource Developed in Newfoundland and Labrador
Amanda Pendergast

Author #1
Janet Fox Beer, RN, BN, IBCLC
Public Health Nurse
Eastern Health

Author #2
Janet Murphy Goodridge, RN, MN, IBCLC
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Author #3
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Pediatrician
Memorial University of Newfoundland

Author #4
Rebecca Rudofsky, MD, CCFP
Family Physician
Memorial University of Newfoundland

Author #5
Clare Bessell, RN, BEd
Perinatal Educator
Eastern Health

Abstract
Background/Rationale: Newfoundland and Labrador (NL) has one of the lowest breastfeeding initiation rates in Canada. Physicians in this province have voiced their concern over a lack of breastfeeding education and expressed the need for a local resource that could be used to help diagnose and manage common breastfeeding concerns.

Methods: A needs assessment was conducted. Twenty family physicians were interviewed in Newfoundland and Labrador to recognize difficulties faced while counselling breastfeeding women. The most common challenges were: diagnosing and managing breast pain, managing poor infant weight gain, prescribing medications safely while breastfeeding and accessing local resources. Family physicians, pediatricians, nurses, lactation consultants and a perinatal educator collaborated to create the Physicians’ Breastfeeding Toolkit. The toolkit was launched in June 2015.

Results: The response to the Physicians’ Breastfeeding Toolkit has been positive. During the summer of 2015, local clinics were targeted to receive visits from the authors of the toolkit. The toolkit was introduced, cases were presented, and the new resource was used to manage the cases. From post-dissemination surveys, family physicians felt the new resource was concise and well organized, with helpful visuals. Family physicians felt an individualized approach of clinic visits to disseminate the toolkit was valuable. Further evaluations will be available in the fall.

Conclusions: The Physicians’ Breastfeeding Toolkit is a new local resource produced by health professionals in St. John’s, Newfoundland and Labrador. The contents stem from a needs assessment of family physicians. Dissemination of the toolkit is underway, with positive evaluations thus far.

Biographies
Dr. Pendergast is an Assistant Professor of Medicine at Memorial University. She graduated from medical school at the University of Ottawa, and from the Family Medicine residency program at the University of British Columbia. Dr. Pendergast’s practice interests include prenatal and intrapartum care, and her research interests include breastfeeding, family medicine obstetrics and curriculum development

Learning Objectives
1. Introduce the Physicians’ Breastfeeding Toolkit
2. Utilize the toolkit to diagnose and treat common breastfeeding problems.
3. Understand early evaluation of the toolkit.
Inadequate Prenatal Care Use and Breastfeeding Practices in Canada: A National Survey of Mothers
Christy Costanian

Abstract
Background: Previous studies have demonstrated that prenatal care (PNC) has an effect on women’s breastfeeding practices.

Learning objectives: This study aims to examine the influence of adequacy of PNC initiation and services use on breastfeeding practices in Canada.

Methods: Data for this secondary analysis was drawn from the Maternity Experiences Survey (MES), a cross sectional, nationally representative study that investigated the peri- and post-natal experiences of mothers, aged 15 and above, with singleton live births between 2005 and 2006 in the Canadian provinces and territories. Adequacy of PNC initiation and services use were measured by the Adequacy of Prenatal Care Utilization Index. The main outcomes were mother’s intent to breastfeed, initiate breastfeeding, exclusively breastfeed, and terminate breastfeeding at 6 months. Multivariate logistic regression analysis assessed adequacy of PNC initiation and service use on breastfeeding practices, while adjusting for socioeconomic, demographic, maternal, pregnancy and delivery related variables. Bootstrapping was performed to account for the complex sampling design.

Results: Breastfeeding intention and initiation were at 75.0%, and 90.0%, respectively, while 6 month termination and exclusive breastfeeding rates were at 52.0% and 14.3%, respectively. Regression analysis showed no association between adequate PNC initiation and services use and performing any breastfeeding practice. Mothers with either a family doctor or a midwife as PNC provider were significantly more likely to have better breastfeeding practices compared those with to an obstetrician.

Conclusions: Health care practitioners have a critical role in serving as advocates of successful breastfeeding during routine PNC by emphasizing education on breastfeeding practices.

Biographies
Christy Costanian is currently pursuing a Doctorate in Epidemiology at York University under the supervision of Dr. Hala Tamim. She holds a Master of Science (MSc) in Epidemiology from the American University of Beirut (AUB). Her research interests include a combination of aging, chronic diseases, and maternal and child health.

Learning Objectives
1. Gain an understanding of the role of inadequate prenatal care initiation and service use on breastfeeding practices such as intention, initiation, 6 month exclusivity and termination among Canadian women.
2. Determine other socio-demographic, maternal and health-related factors associated with good breastfeeding practices.
3. Recommend that health care practitioners be more involved in promoting better breastfeeding practices.
Abstract

British Columbia has the highest prevalence of gestational diabetes mellitus in Canada. Increased ethnic diversity of the obstetric population in BC has been suggested as a possible explanation for these high rates. Using data from 2004/05 to 2009/10, we investigated whether selected ethnic groups account for the high GDM prevalence in BC as compared to Alberta.

Biographies

Brooke Kinniburgh holds a Masters in Public Health with a specialization in Maternal and Child Health. She has been an epidemiologist at Perinatal Services BC since 2011. Her key responsibilities include routine and special analyses, as well as leading reporting efforts including facility-specific indicators.

Lily Lee is the Director, Provincial Registry, Surveillance, Performance, and Analytics at Perinatal Services BC. Lily has over 30 years of nursing experience in perinatal care and has held many leadership roles in advanced practice, education, management, and policy & program development. Lily completed her Baccalaureate Nursing degree from the University of Manitoba, a Master Degree in Nursing from the University of Texas at Austin and a Master of Public Health degree from the University of Washington. Lily has been an Adjunct Professor at the UBC School of Nursing since 1993.

Learning Objectives

1. Describe similarities and differences in the prevalence of gestational diabetes for women of Chinese, South Asian, and Other ethnicities in Alberta and British Columbia;
2. Identify differences in obstetric and neonatal characteristics of GDM-affected deliveries by maternal ethnicity;
3. Discuss reasons for geographic variation GDM prevalence within British Columbia
Best Practice for First Nations Women with Gestational Diabetes
Sherri Leon Torres, Barbara Webster

Author #1
Sherri Leon Torres
Diabetes Nursing Practice Consultant
First Nations Health Authority

Author #2
Barbara Webster
Clinical Nurse Specialist, Maternal Child Health
First Nations Health Authority

Abstract
First Nations women in British Columbia experience higher rates of gestational diabetes. Our aim is to provide evidence based information for health care professionals working with First Nations women about the health outcomes related to gestational diabetes, recommendations and considerations for screening, and the importance of incorporating culturally safe counseling for women and families around diabetes screening and diagnosis.

Biographies
Sherri Leon Torres is a certified diabetes educator who has worked with First Nations communities throughout the province. A graduate from the University of Northern British Columbia in Prince George, her background is in education, having taught at several colleges and universities throughout the province. Sherri has been with the First Nations Health Authority since November 2014 and worked as a community health practice consultant before taking on the diabetes role.

Barbara Webster is a Clinical Nurse Specialist working for the First Nations Health Authority. She is a graduate of Vancouver General Hospital School of Nursing, University of Ottawa (BSCN) and McGill University (MSc). She has worked in 3 provinces and taken on many different roles: nurse in the birthing center and NICU, teaching, community nursing, administration and research. Maternal child nursing has always been her main focus throughout her career. She returned to Vancouver 2 years ago and started working for FNHA in the summer of 2015.

Learning Objectives
1. Identify health outcomes associated with unmanaged gestational diabetes,
2. Identify current screening recommendations globally and how the current Canadian guidelines could be improved for First Nation women,
3. Describe how pre and post counselling for gestational diabetes screening is essential for holistic and culturally informed health care.
CPT1a is a common genetic variant common in some BC First Nations people and it may increase the risk of hypoglycemia in infants and young children.

Biographies

Ms. Lucy Barney, Titqet Nation comes to us from Perinatal Services BC, an Agency of the Provincial Health Services Authority brings 17 years of experience in Aboriginal Health and nursing. She is known for developing culturally appropriate holistic curriculum that is innovative. Previously she worked in Diabetes and then HIV/AIDS education. She chaired the Tripartite Maternal Child Health Committee and her work always included the three partners from idea, design and implementation.

Lucy has dedicated her nursing career in Aboriginal Health and recently was honoured by her colleagues and presented with the UBC Distinction of Nursing Award 2015. Lucy also works in the wellness department as a perinatal and early childhood specialist working collaboratively with all departments and health authorities at the First Nation Health Authority.

Lucy holds a Master of Science Degree in Nursing from the University of British Columbia, Bachelor of Science degree from the University of Victoria.

Barbara Webster is a Clinical Nurse Specialist working for the First Nations Health Authority. She is a graduate of Vancouver General Hospital School of Nursing, University of Ottawa (BSCN) and McGill University (MSc). She has worked in 3 provinces and taken on many different roles: nurse in the birthing center and NICU, teaching, community nursing, administration and research. Maternal child nursing has always been her main focus throughout her career. She returned to Vancouver 2 years ago and started working for FNHA in the summer of 2015.

Learning Objectives

1. Describe CPT1a: background and screening
2. Identify the risk factors and susceptible populations
3. Discuss management to ensure healthy outcomes for First Nation’s infants and young children
4. Increase awareness amongst health care professionals
5. Identify available resources for community members, families and health care professionals
Safety of Labour and Delivery Following Obstetrical Service Closures in Small Community Hospitals in British Columbia, Canada

Jennifer A Hutcheon

Author
Jennifer A Hutcheon
Assistant Professor
UBC Department of Obstetrics & Gynaecology
Epidemiologist, Perinatal Services BC

Abstract
In recent decades, many smaller hospitals in British Columbia have stopped providing planned obstetrical services. We examined the impact of these service closures on the labour & delivery health outcomes of mothers living in affected communities before and after the closure using data from the BC Perinatal Database Registry, 1998-2014. We examined the impact of the closure on a previously published composite measure of labour & delivery safety, the Adverse Outcome Index, which includes adverse events such as birth injury, unanticipated operative procedures, and 3rd or 4th degree tears. We also examined the effect of the closure on transfers to higher levels of care, mode of delivery, and use of obstetrical interventions. Deliveries to women in similar-sized communities unaffected by obstetrical service closures during the same time period were included to control for underlying time trends.

Biography
Dr Jennifer A Hutcheon, Assistant Professor UBC Department of Obstetrics & Gynaecology and Epidemiologist, Perinatal Services BC. She holds New Investigator Awards from the Canadian Institutes of Health Research and the Michael Smith Foundation for Health Research.

Learning Objectives
1. Understand the extent to which obstetrical service closure in small BC communities altered the labour and delivery health outcomes of mothers and newborns in affected communities
2. Become familiar with the Adverse Outcome Index as a summary measure of the safety of labour and delivery
Interdisciplinary, collaborative practice has been proposed as an effective way to improve the quality and sustainability of primary maternity care. For almost two decades, national, provincial, and local strategies have promoted innovative collaborations that value and respect the skills that each provider brings to the delivery of maternity care. In BC, a number of providers have embraced interprofessional collaboration and adapted it to their local context.

Interdisciplinary primary maternity care collaborations with family physicians and midwives, nurses and other allied health professionals were studied within a qualitative framework aimed at exploring innovation, sustainability, professional relationships, teaching and mentoring. Practice innovation has been driven by the desire to deliver primary maternity care that meets the needs of women and communities and attracts and retains primary care providers, particularly in rural and remote BC. Successful collaborations require a core group of passionate, innovative providers supported by funded leadership and administration. Dedicated team-building and skilled communication foster the cohesion, equity and uniformity necessary for a successful interdisciplinary team. Benefits of interprofessional collaboration include: high quality care, increased access for women, increased provider satisfaction and work-life balance, and improved sustainability of maternity services for the local population.

Biographies
Christina is a family physician and a specialist in Public Health and Preventive Medicine. In her role as Primary Maternity Care Lead – Family Practice at Perinatal Services BC, she provides ongoing consultation on initiatives that impact primary maternity care including: data collection and analysis, guideline development, knowledge translation and system planning. She is a clinical instructor at the School of Population and Public Health at the University of British Columbia and provides maternity care at BC Women’s Hospital.

Lee has practiced and taught in urban, rural and isolated communities in British Columbia, Ontario and Nunavut. Her passion for interprofessional engagement and belief in the art of possible is demonstrated by her extensive experience in innovative program and practice development and her continued success in interdisciplinary collaboration. Lee is the Primary Maternity Care Lead – Midwifery with Perinatal Services BC, a Clinical Assistant Professor in the Faculty of Medicine at UBC and practices at BC Women’s and St. Paul’s Hospitals in Vancouver.

Learning Objectives
1. Describe 2 models of interdisciplinary, collaborative primary maternity care in BC.
2. Explain its benefits for women, providers and communities.
3. Explore hot topics in interdisciplinary collaboration and learn key success factors.
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Apple Tree Maternity: A Qualitative Exploration of Rural Collaborative Interprofessional Maternity Care
Tanya Momtazian, Emma Butt, Jeanette Boyd

Abstract

Background/Rationale
There is an emerging interest in exploring interprofessional, collaborative models of maternity care as a possible solution to meeting the shortages of maternity care providers. This study documents the process and experiences of family physicians and registered midwives in establishing and providing collaborative, interprofessional maternity care in rural British Columbia.

Methods
Semi-structured interviews were conducted with key stakeholders working at Apple Tree Maternity. Interviewees spoke to both the process of establishing a new collaborative, interprofessional model of care and the experience of working and providing care within the model.

Results
Four main themes emerged: motivation for collaboration; challenges and barriers to collaborative care; attributes and benefits of collaborative care; and core qualities and recommendations for successful interprofessional collaboration. Based on their experience, the study participants also identified core qualities and recommendations for successful interprofessional collaboration in a rural community: mutual trust and respect; common philosophy of care, mutual commitment and genuine desire to collaborate; clear and effective communication; collaborative model responsive to unique needs of specific community; community support; supportive institutional culture; alternative payment plans and billing structures.

Conclusions
The study revealed a number of attributes to collaboration and identified particular challenges unique to the rural context. Further research in other rural settings is warranted, as well as a need to explore and document the experiences collaborative practice from the client perspective.

Biographies
Tanya Momtazian is a Registered Midwife in Nelson, BC and is a co-founder of Apple Tree Maternity. She has a Masters of Public Health and is interested in community based health initiatives.

Dr. Jeanette Boyd is a Family Physician in Nelson, BC and is a co-founder of Apple Tree Maternity. She works with a number of hats to improve Rural Maternity care in BC.

Emma Butt is a 4th year UBC Midwifery Student. Emma has a Bachelors of Science and a Bachelors of Law and is a new first time mom.

Learning Objectives
1. Discuss the four themes that emerged in the qualitative research
2. Examine the possible replicability of new innovative models of rural maternity care
3. Highlight the next steps in research of collaborative rural maternity care
B4i Seamless Perinatal Transition Team- The Move to Implementation
Michelle Urbina-Beggs, Ruby Gidda

Author #1
Michelle Urbina-Beggs
Clinical Nurse Specialist
Fraser Health Authority

Author #2
Ruby Gidda
Manager
Fraser Health Authority

Abstract
Since perinatal services are provided by a series of different healthcare providers in different settings, there is a need to pay particular attention to the transitions between these providers to ensure a woman’s perinatal journey is seamless. The Seamless Perinatal Healthcare Initiative at Fraser Health was created to address priority gaps in perinatal care across acute and community services, with particular focus on vulnerable women and their families from pregnancy to 8 weeks postpartum. Improvements in the “3 Cs” of communication, coordination, and collaboration are intended to result in improved outcomes for the mother and infant as well as an experience of “seamless care” across various care providers.

In this presentation we will reflect on the lessons learned from the regional implementation of Seamless Perinatal in 8 of Fraser Health’s maternity hospitals and 3 NICU’s and the plan to expand to Pediatrics, in-patient Mental health and emergency. Specifically, we will explore the ways we have found to improve the communication, collaborative care planning, and coordination of care across Public Health, Acute Maternity Care, Primary Care, and Neonatal Intensive Care Units, along with external partners. Challenges we faced – and how we dealt with them – will also be explored.

Biographies
Ruby Gidda RN, BScN, MEd, CCHN(C), Fraser Health
Ruby is the Manager for Chilliwack and Mission Public Health Units with Fraser Health. Ruby’s passion is working in public health and providing a population health lens to her work. She is a strong leader in implementation change in the organization.

Michelle Urbina-Beggs RN, BSN, MN, CCHN(C), Fraser Health
Michelle is a Clinical Nurse Specialist in Public Health with Fraser Health. Michelle brings to her role several years of Public Health Nursing experience as well as a Master’s degree in Nursing. Michelle is passionate about providing nurses with the education and information they need to offer evidence-informed care for their clients.

Learning Objectives
By the end of this presentation, audience members will be able to

1. Appreciate the complexities of working across disciplines and working across acute and community services in perinatal care
2. Articulate the roles of each of the players in perinatal health services in order to collaborate more effectively
3. Articulate how seamless perinatal transition teams impact client service
Abstract
The typical childbirth education experience in Canada consists of 4 to 6 sessions preparing parents for childbirth, plus 1 or 2 sessions on basic baby care and breastfeeding, all completed by 36 weeks of pregnancy. This format is unable to provide timely information or support to parents during the most difficult transition period, the early weeks at home with baby.

Social support can improve maternal mental health in the postpartum period. Most prenatal classes are not able to provide such support as the series ends before the birth. In addition, breastfeeding rates increase when women have access to prenatal education, plus peer support postnatally. Lack of time, tiredness, isolation and low confidence are barriers for families to create or expand a social support network after the birth of their baby. Birth and Babies is a well-established model of how perinatal educators can provide support for new families. Parents attend the program for 10 weeks, starting at week 34 in pregnancy, have their baby during the series, and attend the remainder of the series with their baby. In addition to the support provided by the educator, the group becomes a social support network for its members.

By the end of this session, attendees will be able to describe three improved birth or parenting outcomes seen among Birth and Babies participants, have the opportunity to identify potential barriers to the implementation of the Birth and Babies format of perinatal education in their own practice setting, and identify strategies for overcoming those barriers.

Biographies
Nicole Brouwer has been teaching perinatal classes with Alberta Health Services for 10 years. Before becoming a perinatal educator, she was a neuroscientist, and she adores combining her passion for science and research with her love of teaching and birth. She has recently completed a Master’s degree in adult education, and is the proud mother of two beautiful girls.

Debby Corscadden has been a perinatal educator with Alberta Health Services for 23 years. She has contributed to numerous parenting resources used throughout Alberta and helped create the Birth and Babies program. She is a registered nurse with experience in pediatrics and community health nursing.

Learning Objectives
1. Benefits of Birth and Babies: The participants will be able to name 3 benefits to new parents of the Birth and Babies format of perinatal education.
2. Birth and Babies outcomes: The participants will be able to name 2 improved birth or parenting outcomes seen among Birth and Babies participants.
3. Barriers to implementation and solutions: The participants will have the opportunity to identify potential barriers to the implementation of the Birth and Babies format of perinatal education in their own practice setting, and identify strategies for overcoming those barriers.
Abstract

Provision of postpartum care in the community has been a key public health service that has existed in some format for more than 40 years, and since the initial Maternity Care at Home projects in the 1990’s has been a part of the continuum of maternity care in BC. In 2012, the Healthy Start Initiative: Provincial Perinatal, Child and Family Public Health Services (April 2013) document outlined the universal and enhanced services that should be available to all families in the postpartum period.

VCH has recently completed an evaluation of the postpartum services it provides, and based on the findings has revised the public health postpartum practice guidelines. A key concern from the evaluation was that clients with risk factors may not be accessing services universal services. Using the principals of Proportionate Universalism, the revised guideline supports the engagement of families who many experience barriers to access and/or utilization of universal services, and to standardize the identification of families with risk factors who may benefit from enhanced public health services.

Biographies

Joanne Wooldridge is the Regional Leader, Early Childhood Development for public health at Vancouver Coastal Health. Her nursing practice has been exclusively with families with young children, including maternity and public health. Her current focus is on the implementation of best public health practices in the areas of reproductive health and healthy infant and child development.

Rachel Douthwaite is the Clinical Educator for Public Health Nursing on the North Shore. Her nursing practice has focused on infant, child, youth, and women’s health. She has worked in maternity, post-sexual assault care, and public health. She is also a lactation consultant and is passionate about supporting mothers and babies to meet their breastfeeding goals.

Learning Objectives

1. Understand the provincial public health service goals for families in the postpartum period, both universal and enhanced, particularly the role of public health nursing in the continuum of support
2. Understand VCH’s approach to postpartum care in the community and identification of families who may benefit from additional public health services
3. Know how to refer a client in the perinatal period to public health for support
What Makes Good Healthcare: A Mother’s Perspective

Tamara Taggart
Panel

Normalizing Birth from Policy, Practice and Lived Experience

Michelle Butler, Sarah Fawzy, Sheryl Alger, Susan Lin, Sara Sandwith
Supporting Both Breast Feeding and the Baby at Risk for Hypoglycemia
Debra O’Flaherty

This session will look at which newborns and when they should be screened for hypoglycemia while maintaining a breast feeding friendly/supportive practice.

Learning Objectives
1. Summarize the existing guidelines for the management of newborns at-risk for hypoglycemia
2. Discuss interventions for these babies that promote breastfeeding
3. Provide an opportunity for feedback into future clinical practices
Got Milk? Expansion of the BC Women's Provincial Milk Bank
Frances Jones

Author
Frances Jones, RN MSN IBCLC
Coordinator
BC Women’s Provincial Milk Bank and
BC Women’s Lactation Service
BC Women’s Hospital and Health Centre

Abstract
BC Women’s Provincial Milk Bank opened in 1974. It is the oldest milk bank in Canada. In the last ten years, the bank has increased in size and in 2013 with the provision of BC Government funding, the bank became a provincial resource. Significant expansion and provincial action is taking place. This session covers the operations of the bank in 2016 and the role of each BC health authority.

Biography
Frances Jones is the Coordinator of the BC Women’s Lactation Service and the BC Women’s Provincial Milk Bank. She is a co-founder of the Lactation Service in 1988 and has been managing the Milk Bank since 2000. Frances is the chair of the BOD of Quintessence Foundation, well known for holding the annual Breastfeeding Challenge. She has spoken at a number of conferences on breastfeeding and milk banking. Today her topic is Got Milk? Expansion of the BC Women’s Provincial Milk Bank.

Learning Objectives
Upon completion of this session the participants will be able to:

1. Briefly describe the history of donor milk in Canada
2. List four steps that ensure a safe product
3. Outline availability of donor milk in BC
4. Name two actions each participating health authority is required to undertake
**Background**
Congenital cytomegalovirus (cCMV) infection occurs in ~7 per 1000 live births, and is a major cause of childhood deafness and intellectual disability. Most infections are asymptomatic. However, currently even symptomatic cCMV is rarely diagnosed in BC, which results in missed opportunities to provide beneficial care. Diagnosis of cCMV requires direct detection of virus in saliva or urine prior to 3 weeks of age. Early oral antiviral treatment of symptomatic cCMV improves hearing and neurocognitive outcomes. Therefore, strategies are needed to efficiently diagnose and treat newborns with cCMV infection.

**Learning objectives**
Become familiar with the indications and appropriate methods for cCMV testing. Understand the need for timely referral and workup of infected newborns.

**Current practice and proposed changes**
Currently, cCMV testing is based on clinical suspicion, typically using a urine sample. A new program sponsored in part by the BC Early Hearing Program will provide cCMV testing for all newborns that fail hearing screening using a convenient oral swab. Providers and families will be immediately notified of positive results to facilitate appropriate care.

**Evaluation strategies**
The number of newborns tested for cCMV and positive results will be tracked. In addition, the frequency of treatment and clinical outcomes will be measured to assess program effectiveness and cost.

**Implications**
This program will identify most hearing loss due to cCMV at birth. Diagnosis of infants with other cCMV-related disease may also improve through the increased awareness of cCMV. Program outcomes will be analyzed and used to optimize strategies to reduce the burden of cCMV-related disease in BC.

**Biographies**

Dr. Gantt is an Associate Professor of Pediatric Infectious Diseases at UBC. He received his MD and PhD degrees from New York University, and did his residency and fellowship training at the University of Washington in Seattle. In addition to caring for patients at BC Children’s Hospital, Dr. Gantt conducts research on cytomegalovirus and related infections at the Child & Family Research Institute in Vancouver.

Sonya Vandriel is a Senior Practice Leader in the Neonatal Intensive Care Unit at BC Women’s Hospital. She obtained a Bachelor of Science in Nursing from Queen’s University and a Masters of Nursing from the University of Toronto. She has experience in various clinical and leadership roles as a registered nurse, clinical coordinator and subject matter expert at Mount Sinai hospital and St Michael’s hospital in Toronto.

Melanie Basso is the Senior Practice Leader for BC Women’s Hospital, involved in advanced planning for women with complex pregnancies.
A Historical and Medical Critique of Circumcision / Intact Babies: Avoiding Clinical Errors
Christopher L. Guest, Kira Antinuk

Abstract
The first segment of this joint session will explore the historical origins of ritual infant circumcision and its religious significance to various cultures throughout history. The medicalization of circumcision during the Victorian era can be attributed to social, religious and moral values concerning sexuality and cleanliness, with no real foundation in medical science. Even in the modern era, there is persisting ignorance and misunderstanding regarding the sexual and mechanical function of the human prepuce. Evolutionary perspectives on the human prepuce can provide evidence of this structure’s importance, in terms of reproductive efficiency and resistance to disease. The session will also explore and critique the contemporary medical arguments used to justify and perpetuate non-therapeutic infant circumcision. Finally, the ethical debate surrounding infant circumcision will be considered from the framework of the fundamental principles of medical ethics and contemporary declarations regarding human rights.

With the declining incidence of non-therapeutic male infant circumcision in Canada, health care providers see more intact babies than circumcised babies. As Canada moves toward abandoning infant circumcision and other forms of non-therapeutic child genital cutting, misconceptions about care of the intact penis remain, leading to inaccurate patient education and care, including premature forced foreskin retraction (PFFR). The second portion of this joint session will explore the normal development of the penile prepuce and the phony phimosis diagnosis and will provide participants with current clinical guidelines on safe hygiene for intact babies, including how to catheterize an intact baby and avoid PFFR.

Biographies
Christopher L. Guest MD, FRCPC is the Chief of Radiology at the Royal Victoria Regional Health Centre in Barrie, Ontario, Canada. He completed medical school and radiology residency at the University of Toronto and clinical fellowship in vascular and interventional radiology at St. Michael’s Hospital in Toronto.

Kira Antinuk, RN, BScN is a Registered Nurse Medical Adjudicator for the Government of Canada. She is currently completing her Master’s degree at the University of Victoria.

Learning Objectives
1. Learn how ritual male infant circumcision became medicalized as well as how it relates to contemporary medical ethics
2. Update on how to care for intact babies, including safe catheterization technique and how to avoid PFFR during physical exams
3. Live discussion following this joint session will provide opportunities to explore challenging cases and practice questions
Creating Healthy Babies: Baby Brain Development, Nutrition, and Traditional Knowledge

Rene Lerat, Rhonda Kayseas

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Abstract

Studies have shown that young parents would like to know more about brain development and nutrition for their growing baby’s (Best Start Resource Centre, 2011). Within First Nations contexts, it may be difficult for First Nations parents to obtain such prenatal information. Specifically, these parents may have difficulty accessing culturally appropriate health information due to geographic and economic barriers, and healthcare providers lack of understanding of aboriginal health (Exner-Pirot & Butler, 2015).

This interactive session will address how to share prenatal information with young First Nation mothers and fathers in a way that is meaningful to their unique worldview. A young First Nations nursing student and Treaty 4 Education Alliance Director will share the process and outcome of a perinatal workshop they co-created for young parents in a small First Nation community in rural Saskatchewan. Holistic cultural teachings based on First Nations child and plant knowledge were combined with western knowledge on brain and child development; the goal is to promote awareness of how early childhood health is linked to the prevention of growth and development challenges and ultimately, health promotion throughout the lifespan.

Findings inform a practical culturally meaningful resource and guidelines for how to share and value traditional knowledge. Furthermore, the findings can flourish the identity and connection to mother earth among First Nations people for the creation of healthy babies, healthy mothers, and healthy families.

Biographies

Rene Lerat, currently a 3rd year BScN student at the University Of Saskatchewan College Of Nursing. I am a 25 year old Cree First Nations woman from Cowessess First Nation. Also have my Practical Nursing Diploma and an employee with the University of Saskatchewan as a Research Assistant.

Rhonda is the Assistant Director of the Treaty 4 Education Alliance. She has a BEd and MEd. She has extensive teaching experience in elementary education and in community development.

Learning Objectives

1. Share the authors’ approach to developing the event, and lessons learned in our presentation.
2. Provide attendee feedback in an interactive way in and effort to improve our idea and make it applicable to local needs. Engage in a presenter and audience learning discussion.
3. Share knowledge and build capacity so that attendees could deliver similar workshops in their communities across Canada.
New Priorities and Advances in Well-Baby/Well-Child Care for Children 1 Week to 5 Years of Age from the 2014 Rourke Baby Record
Leslie Rourke

Abstract
Evidence has accumulated that the early years are pivotal, not only for future learning, but also for physical, mental, and emotional health throughout life. This understanding of the importance of the quality of early childhood development and its impact on later health outcomes has increased our attention on how the structure and process of well-baby/child visits can promote long-term health and well-being.

The Rourke Baby Record (RBR) is a structured and evidence-based tool for preventive care of children from 1 week to 5 years of age that is widely used across Canada by family doctors and other primary healthcare providers. First published in 1985 and most recently updated in 2014, the RBR has been validated and is endorsed by the Canadian Paediatric Society (CPS), the College of Family Physicians of Canada (CFPC), and Dietitians of Canada (DC). The RBR website (www.rourkebabyrecord.ca) includes interactive links to resources for both healthcare providers and for parents.

Using a case-based approach, this session will highlight new or updated information from the 2014 RBR in many areas of preventive paediatric care for infants and young children from 1 week to 5 years of age. This includes growth monitoring, introduction of solid foods and allergenic foods, safety information, healthy sleep habits, healthy activity, oral health, and developmental milestone surveillance. Presented by Leslie Rourke, family physician, it will appeal to primary healthcare providers, learners, teachers, researchers, and policy makers, as well as to parents of young children.

Biographies
Leslie Rourke is a Family Medicine Professor at Memorial University. Prior to moving to Newfoundland in 2004, she was a rural family doctor for 25 years in Goderich Ontario, and a faculty member at Western University. She and her husband, Dr. James Rourke, developed the Rourke Baby Record when they started medical practice in 1979. Leslie enjoys yoga, hiking, skiing, and travel, and has been extensively educated in well baby/child issues by her three children.

Learning Objectives
1. Describe new preventive care information for infants/young children including growth monitoring, timely introduction of solid foods and allergenic foods, healthy sleep habits, oral health, etc.
2. Demonstrate the most efficient use of the 2014 Rourke Baby Record and its related parent and healthcare provider resources (www.rourkebabyrecord.ca)
3. Gain knowledge of related initiatives in early childhood
The Physiological Effects of Immediate to Early Skin-to-Skin Contact on Mother and Newborn Transition: A Systematic Review

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Abstract

Background/Rational: Skin-to-skin care (SSC) of mother and newborn at birth has been adopted as best practice globally to facilitate early and long-term breastfeeding, psychological health and bonding, and thermal stability. The transition from intra-uterine to extra-uterine life is a traumatic and fragile time for the newborn. Studies over the past several decades have shown the value of SSC for improving physiological stability of late preterm and term newborns. The purpose of this systematic review was to investigate how SSC affects both maternal and newborn biological and physiological transition in the early postpartum period.

Methods: A systematic review was conducted of studies published from 2009-2015 that investigated physiological, biological, or biochemical effects of SSC in the immediate or early postpartum period (within 1-2 hours of delivery).

Results: Results indicated that newborns receiving SSC in the immediate to early postpartum period demonstrated greater thermal stability, more rapid thermal control, hemodynamic transition with higher SpO2, and achieved a stable heart rate sooner than those newborns that did not experience SSC. Maternal effects included increased natural oxytocin levels and a shortened third stage of labour.

Conclusions: Skin-to-skin care between mother and neonate in the immediate postpartum phase improve physiologic and biologic stability for both members of the dyad. Reduced stress reactivity and more efficient thermal and hemodynamic adjustments were observed. Even though preliminary results are promising, further research is needed to strengthen the effects of this simple nursing intervention.

Biographies

I have been an RN for 23 years working in perinatal/neonatal practice. I am currently practicing full time in LDR at Royal Inland Hospital, Kamloops, providing direct care to intrapartum patients. I am also attending UBCO on a fulltime basis in the MSN program with a graduation date of December 2015. I plan to use the results of this research to inform future research in further graduate studies in perinatal evidence-based clinical practice.

Learning Objectives

1. Describe the critical physiological and biological impact that skin-to-skin contact at birth has on mother/newborn transition
2. Compare the outcomes of skin-to-skin contact on mothers and newborns vs. outcomes for dyads not receiving the intervention
3. Examine and critique routine clinical practices that either interfere with or facilitate skin-to-skin contact at birth
Mother Baby Care... Supporting Mothers and Babies to Stay Together...
One Couple at a Time!
Julie de Salaberry, Suzanne Hetzel Campbell

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Abstract

Background/Rationale

Model of Care

• Mother Baby Care (MBC) project to transition us from our current ‘open bay’ to a 70 bed single room design NICU.
• MBC is grounded in a philosophy of Patient and Family Centered care characterized by mutual respect and shared decision-making between the parent and health care team.
• Aligns with Neo-BFHI guidelines

Separation

• MBC prevents separation, enhances opportunities for Kangaroo Mother Care and proximity for parents to participate in their baby’s care.
• Separation is noted in the literature to be barrier to healthy maternal infant attachment, and linked to maternal anxiety and depression, poor breastfeeding outcomes and negatively impacts neuro-developmental outcomes of the newborn.

Kangaroo Mother Care

• There is a substantive body of literature regarding the benefits of early, prolonged and when possible continuous KMC particularly for premature infants.

Partners in Care

• Evidence exists regarding the benefits of an integrated model of care where parents are invited and supported to provide as much hands on care as possible.
• Benefits include reduced length of stay, improved growth, enhanced readiness for discharge, reduced nosocomial infections, reduced safety events, enhanced attachment and increased maternal confidence, reduced anxiety improved long term neuro-developmental outcomes and enhanced parent and family experience.
Method

- Renovation of two parent bedrooms adjacent to the NICU
- Developed MBC education workshop, preceptorships and in-situ simulation
- Redesign site wide services for MBC
- Change Management strategies

Evaluation

- LOS metrics and breastfeeding outcomes
- e-Family Experience Survey
- Staff Awareness Survey

Biographies

Julie de Salaberry is the Programs Leader for the Neonatal Program at BC Women’s Hospital and Health Centre, the provincial referral center for the most acutely ill newborns and their families in BC and Yukon. An experienced operational leader and neonatal nurse clinician, Ms. de Salaberry is committed to improving clinical outcomes and enhancing the lived experience of newborns, women and their families through collaborative practice and innovative approaches to patient and family centered care.

Dr. Suzanne Campbell (PhD University of Rhode Island, 1996) is Director of the School of Nursing at the University of British Columbia. A seasoned educator, she uses technology and is an early adopter of new pedagogy. Dr. Campbell is familiar with Quality and Safety Nursing Education concepts and brings curriculum expertise to bridge the gap between education and practice. An IBCLC she is presently part of a NeoBFHI research project in Brazil.

Learning Objectives

1. Identify the positive effects of MotherBaby Care on maternal and infant health outcomes and infant development
2. Identify change management strategies that support the practice change and evolving unit culture
3. Outline neuro-developmentally supportive methods that enhance maternal infant attachment
4. Apply concepts of MotherBaby Care such as Kangaroo Mother Care to scenarios they have identified in the practice area to overcome barriers and challenges
5. List the benefits of partnering with parents in the care of their fragile, premature infant
6. Apply guiding principles of Neo-BFHI to the developing practice of MotherBaby Care
Abstract
Background: Neonatal Intensive Care Unit (NICU) parents’ experiences with safety culture is mainly unknown. Clinicians provide their perspectives of safety culture but a new angle of safety intelligence is required including parents’ perspectives.

Objectives: This project aims to discover the extent NICU parents identify safety domains using the Yorkshire Contributory Factors Framework (YCFF).

Method: This qualitative study interviewed six parents of infants in an academic specialized care NICU. Parents were asked to describe experiences (unstructured) related to 12 of the YCFF safety domains (structured). Narrative sections were matched to safety domains using YCFF definitions with further coding done to discover emerging themes.

Results: Parents provided experiences for all 12 safety domains identifying most frequently communication, team, dignity and respect, and workload. Emerging themes were parental choice for engagement, supporting role of parent, “knowing” the infant to optimize care, fluidity of team members, and the need to watch over infant for safety.

Conclusion: Parents as they journey with their infant during care are exposed to safety domains experiencing the safety culture or health of the NICU. New care models (e.g. family integrated care) will increase the parents’ engagement and involvement as primary care providers increasing exposure to safety domains. Healthcare leaders need a new angle of safety intelligence that recognizes the parents’ experiences of safety culture. Obtaining information based upon these experiences is crucial to proactively design safer systems for neonatal care (Carayon et al., 2014; Frey et al., 2009; Longtin et al., 2010; Schwappach, 2008; Vincent & Davis, 2012).

Biography
Valoria Hait is the Quality and Safety Leader in the Neonatal Intensive Care Unit (NICU) at BC Women’s Hospital and Health Centre. She holds a Lean Leader Certification and a Masters in Science of Healthcare Quality from Queen’s University. Her desire to enhance the care to critical infants and to support NICU families led to two current research projects: Exploring the parents’ experiences of safety culture and development of a NICU skin risk assessment tool.

Learning Objectives
1. Identify the safety domains and categories that NICU parents experience to understand what is of importance to parents to feel safe.
2. Reflect upon the aspects of safety culture and explore means to obtain assessments from clinicians and parents to make improvements to neonatal care.
Old Need, New Technology: Providing Perinatal Support via Text-Message and Online-Only Group

Jody Perkins

Abstract

For 43 years, Pacific Post Partum Support Society (PPPSS) has provided information, assessment, referrals and support to women and their partners with postpartum depression and/or anxiety (PPD/A). Our core services include in-person facilitated support groups in the Lower Mainland and telephone support province wide. However, ongoing assessment of our service indicates we are not reaching all struggling new parents in BC. Research indicates feelings of isolation and lack of support contribute to a difficult perinatal adjustment and our pilot demonstrates creative delivery can reach underserved populations with vital support.

This past year Vancouver Coastal Health funded a PPPSS pilot to deliver perinatal support in two new ways: individual support via text message and group support in an online format. These methods were selected through long-term consultation with underserved communities. For example, service providers in Aboriginal communities indicated that support via text message would serve struggling parents who had very limited cell phone voice minutes. And mothers living in remote communities have often expressed desire to attend a perinatal support group, but indicated their community had none.

In-progress evaluation includes analysing patterns of use for both pilots, as well as completing an evaluation and pre- and post-group EPDS with online group participants. Preliminary use patterns indicate that the pilots have reached parents living in isolated and currently underserved communities. Preliminary participant evaluations have indicated that this support has had a positive impact. We are seeking ongoing funding to continue to provide these services.

Biography

Jodine Perkins, MA/MLS, a PhD candidate in Folklore at Indiana University Bloomington lives and works in Vancouver, BC. She is a project manager and digital curator who facilitates community-led projects with social service providers and cultural organizations.

Learning Objectives

1. Understand how supporting moms and breaking isolation are vital to women recovering from PPD/A
2. Gain understanding on how alternative methods of support are important to reach moms who may have barriers to accessing traditional supports
A Randomized Controlled Trial to Evaluate the Effect of Telephone-Based Interpersonal Psychotherapy Provided by Nurses for the Treatment of Postpartum Depression

Cindy-Lee Dennis

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Abstract
Objective: To evaluate the effect of telephone-based interpersonal psychotherapy (IPT) provided by trained nurses for the treatment of PPD.

Methods: A multi-site randomized controlled trial was conducted where healthcare providers from 36 health regions across Canada referred mothers <24 weeks postpartum who scored >12 on the Edinburgh Postnatal Depression Scale (EPDS). Eligible and consenting mothers with a clinical diagnosis of major depression, as diagnosed using the Structured Clinical Interview for DSM-IV (SCID), were randomized to either the control group (standard community PPD care) or the intervention group (standard community PPD care plus 12 weekly telephone-based IPT sessions provided by trained nurses). Research nurses blinded to group allocation telephoned all participants at 12, 24, and 36 weeks post-randomization.

Results: In total, 241 mothers participated in the trial. Mothers who received the IPT intervention were significantly less likely to be clinically depressed and anxious across the postpartum period than those in the control group. Further, mothers in the IPT group had higher levels of relationship consensus and cohesion. Mothers were highly satisfied with the IPT intervention. Health service use results and intervention fidelity data will also be presented.

Conclusion: Telephone-based IPT provided by trained nurses in Ontario was an effective treatment for clinically depressed mothers living across Canada. Mothers felt the nurses were highly competent and that the provision of IPT via telephone was convenient and met their treatment needs. Telephone-based IPT may be a novel treatment option for mothers with PPD living in rural and remote areas.

Biographies
Dr. Cindy-Lee Dennis is a Professor in the Faculty of Nursing and Adjunct Professor in the Department of Psychiatry at the University of Toronto. She holds a Canada Research Chair in Perinatal Community Health and was further appointed the Shirley Brown Chair in Women’s Mental Health Research at Women’s College Research Institute. She is the principal investigator of five large, multi-site studies and is a co-investigator on eighteen other research projects concerning the care of pregnant and postpartum women. She holds over $5.6 million in funding from the Canadian Institutes of Health Research (CIHR) as a principal investigator and has over 140 peer-reviewed publications. She has completed five Cochrane systematic reviews related to perinatal (antenatal and postpartum) depression and anxiety. She also developed the Breastfeeding Self-Efficacy Scale, the most widely used breastfeeding scale internationally.

Learning Objectives
1. Understand the principles of a well-designed randomized controlled trial
2. Describe how nurses can be trained to deliver IPT
3. Describe an interpersonal psychotherapy intervention for the treatment of postpartum depression
Safe Sleep, Day and Night: Metro Vancouver Mothers’ Experiences Regarding Infant Sleep Safety
Annie Lau, Wendy Hall

Abstract
Background: Sudden infant death syndrome (SIDS) is the third leading cause of death for British Columbian infants younger than one year of age. Sudden unexplained infant death (SUID) is increasing in British Columbia and is linked with unsafe sleep environments. Although sleep safety guidelines have been developed, limited evidence is available on how parents take up guidelines. No studies have explored Canadian mothers’ experiences regarding infant sleep safety.

Methods: A qualitative descriptive study design, utilizing semi-structured interviews and constant comparative analysis, was employed to explore Metro Vancouver mothers’ experiences regarding sleep safety.

Results: The core theme, Infant Sleep Safety Cycle, represents a cyclical process encompassing sleep safety from the prenatal period to the first six months of infants’ lives. The cyclical process included five segments: mothers’ expectations of sleep safety, their struggles with reality as opposed to maternal visions, modifications of expectations, provision of rationale for choices, and shifts in mothers’ views of infants’ developmental capabilities.

Mothers indicated infants’ sleep safety cycles were influenced by four factors: perceptions of everyone’s needs, familial influences, attitudes and judgments from outsiders and resource availability and accessibility.

Conclusions: To manage infants’ sleep, mothers reframed sleep safety guidelines and downplayed the risk of SIDS for all forms of sleep at all times. During prenatal and postpartum periods, strategies can influence mothers’ efforts to adhere to sleep safety principles. Health care providers can support mothers’ efforts to manage their infants’ sleep challenges.

Biographies
Annie Lau has extensive clinical expertise working with families with children of the early years in public health nursing, specializing in marginalized populations and multiethnic sectors. She currently is the Clinical Practice Lead for Vancouver Coastal Health.

Dr. Wendy Hall is a Professor in the School of Nursing at the University of British Columbia, working in the area of infant sleep for 15 years. She is an active researcher with over 75-refereed publications.

Learning Objectives
1. Demonstrate increase in knowledge and understanding of mothers’ contextual circumstances and challenges regarding infant sleep safety by describing their experiences through the infant sleep safety cycle
2. Describe the factors that influence mothers’ experience with infant sleep safety
3. Identify and explore collaborative strategies to incorporate in their clinical practice, education and research to support mothers to follow safe sleep
Screening for Postpartum Anxiety: Is the EPDS Enough?

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Abstract

Background: Screening for postpartum depression is now routine in many places, including BC. The Edinburgh Postnatal Depression Scale (EPDS) is the most commonly used self-report instrument for the assessment of postpartum depression, and is the measure used to assess for postpartum depression in BC. Although the EPDS contains an anxiety component, it is likely insufficient to detect clinically important anxiety among women who are not also depressed.

We have recently complete a study of postpartum mood and anxiety disorder prevalence, in which we also included administration of the EPDS.

Objective: A key objective of this research was to determine if additional screening, beyond the EPDS, is required in order to adequately detect anxiety disorders among postpartum women.

Results: This study involved 310 women. Anxiety disorders affected more than three times the number of postpartum women compared with depression (17% versus 5%). Our findings do not support the exclusive use of the EPDS as a screening tool for postpartum anxiety disorders. Specifically, neither the full EPDS, nor the anxiety specific EPDS items adequately detected clinically significant anxiety among new mothers in our sample.

Learning Objectives
1. How common are postpartum depression and anxiety?
2. How is postpartum depression currently screened for?
3. Does postpartum depression screening also detect most cases of postpartum anxiety?
4. How should postpartum anxiety be screened for?
Trajectories of Perinatal Depressive and Anxiety Symptoms
in a Community Cohort

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Abstract
Objective: The evidence on the trajectories of perinatal depression is mostly based on studies composed of women at high-risk for poor mental health. Research on maternal anxiety trajectories is also scarce. Using a large community cohort, All Our Babies study, in Alberta, Canada, we examined trajectories of perinatal depressive and anxiety symptoms and compared characteristics of women across trajectories.

Methods: Anxiety and depressive symptoms were measured at the 2nd and 3rd trimesters and at 4th and 12th months postpartum, among 1,445 women recruited from May 2008 to December 2010. Semiparametric group-based mixed modeling was performed to identify the optimal trajectory shape, number of groups, and proportion of the sample belonging to each trajectory. Model fit was evaluated using the Bayesian Information Criterion. Multinomial logistic regression analysis was conducted to compare characteristics across the trajectories.

Results: Five distinct trajectory groups with constant and variable patterns were identified for both depressive and anxiety symptoms: "Minimal", "Mild", "Antepartum", "Postpartum", and "Chronic". Being a new immigrant and an infertility history (OR varied from 2.12-2.60) were associated with membership in the "Antenatal" groups. Younger maternal age (OR 3.61; 95%CI 1.15-11.36) and being single (OR 4.09; 95%CI 1.48-11.31) were risk factors of chronic depression.

Conclusion: Heterogeneity of anxiety and depressive symptoms highlights the importance of multiple mental health assessments during the perinatal period. The patterns and intensity of postpartum depression differed between community and high-risk samples, underlining the significance of defining suitable cut-offs. Research to examine the impact of these trajectories on child outcomes is needed.

Biography
Hamideh Bayrampour is an Assistant Professor in the Midwifery Program at the University of British Columbia. Hamideh earned her BSc and MSc from Iran and her PhD from the University of Manitoba. In her postdoctoral studies, she studied pregnancy-related anxiety. Her research interest is maternal mental health.

Learning Objectives
1. The learners will be able to describe the patterns and characteristics of anxiety and depressive symptoms in the perinatal period.
2. The learners will understand the relationship between these trajectories and various maternal characteristics.
3. The learners will recognize the importance of maternal mental health assessment across the transition to parenthood.
Immigrant Women’s Experience of Postpartum Depression in Canada: A Narrative Synthesis Systematic Review
Gina Higginbottom, Joyce O’Mahony

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Abstract
Background: Understanding the ethnocultural orientation of immigrant women in maternity is critical for their successful integration and for social cohesion. A key aspect is the need for timely identification and treatment of postpartum depression, which has high prevalence in this vulnerable population. Funded by Canadian Institute for Health Research and partnering with key stakeholders to ensure topic relevancy, we conducted a narrative synthesis systematic review of quantitative and qualitative primary research (Popay et al, 2006) to answer the research question:

What are the ethnoculturally defined patterns of help-seeking behaviours and decision-making and other predictive factors for therapeutic mental health care access and outcomes in respect of postpartum depression for immigrant women in Canada?

Methods: Guidelines for systematic and grey literature review were followed to identify and select literature. Methodological quality was appraised using tools developed by the Centre for Evidence Based Management. The narrative synthesis methodology relied primarily on text to summarize and explain findings, using four elements: a) developing a theory of why and for whom, b) developing a preliminary synthesis, c) exploring relationships in the data, and d) assessing the robustness of the synthesis.

Results: Our review revealed precursors to differences in health care access and utilization by immigrant women with depressive symptomatology and these differences are factors recognized to be critical determinants of effectiveness of services and patient/client outcomes.

Analysis of 22 studies led to the development of four interrelated themes:

(a) effects of immigration; (b) social support, isolation and poverty; (c) ethnocultural determinants;
(d) gender roles and relationships.

Conclusions: Findings will have direct relevance in guiding provision of health care services, identify themes for wider application for service delivery and public health initiatives in relation to providing culturally acceptable and appropriate care this immigrant population.
Biographies

Gina Higginbottom is The Mary Seacole Professor of Ethnicity and Community Health at the University of Nottingham, England. She is a qualified nurse, midwife and health visitor and her clinical career as a nurse spans 22 years. Formerly a Canada Research Chair holder at the University of Alberta, her research program on ethnicity and health focuses mainly on international migration and maternity. Prof Higginbottom holds a substantive publication record and her Sage Publications text book ‘Participatory Qualitative Research Methodologies in Health’ demonstrates her commitment to participatory models of research.

Joyce O’Mahony’s background as a community health nurse encouraged her to explore further the mental health care experiences of immigrant women. Her research to date has been motivated by the need to enhance opportunities for improved health through the perspectives of immigrant and refugee women in the postpartum period.

Learning Objectives

Our review will have a substantive and sustainable impact on the creation and enhancement of mental health care programs such that they will provide culturally acceptable and appropriate care in immigrant women with postpartum depression.
Changing Provincial Regulations – the Newborn Eye Prophylaxis Story
Janet Walker

Author
Janet Walker
Director, Provincial Knowledge Transformation and Acute Care

Newborn eye prophylaxis has been a required practice in BC for many years. The 2015 release of the CPS position statement "Prevention of Ophthalmia Neonatorum" recommended provinces rescind regulations that made eye prophylaxis mandatory. At the request of the Provincial Health Officer, PSBC in collaboration with the BC Centre for Disease Control convened a working group to address this issue. This session will describe the steps taken to change law and practice in BC.

Biography
Janet is a registered nurse whose past clinical experience includes postpartum, high risk antepartum, labour and delivery, childbirth education and outpatient diagnostic counselor. She held a leadership position as the manager of Antepartum/Postpartum in the Acute Perinatal Program at B.C. Women's Hospital for 5 years.

Janet obtained her bachelor and master's degrees at UBC.

Currently she is the Director of Provincial Knowledge Transformation and Acute Care at Perinatal Services BC. Her portfolio includes a wide range of activities including breastfeeding, guideline revision and development, fetal health surveillance education, neonatal education, form development and quality initiatives. She enjoys teaching and connecting with external stakeholders around issues that are important to them.

Learning Objectives
1. Advances in Clinical Practice and Research Across the Continuum
2. Review the practice of mandatory eye prophylaxis in BC
3. Examine the steps taken to lead the change process
4. Explore the impact of rescinding mandatory eye prophylaxis
Prevention of Congenital Syphilis in the Context of Rising Syphilis Diagnoses in BC

Jason Wong, Troy Grennan

Abstract

Similar to many jurisdictions in developed countries around the world, rates of syphilis diagnosis in BC have been increasing since 2010. From January to October 2015, there were 626 cases of infectious syphilis reported in BC, which already exceeds the annual counts of syphilis in recent history. While over 80% of these 626 cases are among gay, bisexual, and other men who have sex with men, there is concern that there may be spillover into the maternal population. The last case of congenital syphilis in BC was in 2013. However, in USA, the rate of congenital syphilis has increased 38% from 2012 to 2014. The intention of this session is to review the epidemiology of syphilis in BC, raise awareness of congenital syphilis, and discuss strategies to prevent congenital syphilis.

Biographies

Dr. Troy Grennan completed Internal Medicine training at the University of Toronto, and combined Infectious Diseases and Medical Microbiology training at McMaster University. He currently works as the Physician Lead - HIV/STI Program at the BC Centre for Disease Control.

Dr. Jason Wong is a graduate of the Public Health and Preventive Medicine/Family Medicine residency program at UBC. He currently works as a Physician Epidermiologist at the BC Centre for Disease Control, responsible for the surveillance of HIV/STI, TB, and Hepatitis C.

Learning Objectives

1. Review the epidemiology of syphilis in BC
2. Raise awareness of congenital syphilis
3. Discuss strategies to prevent congenital syphilis
Biographies
Brooke Kinniburgh holds a Masters in Public Health with a specialization in Maternal and Child Health. She has been an epidemiologist at Perinatal Services BC since 2011. Her key responsibilities include routine and special analyses, as well as leading reporting efforts including facility-specific indicators.

Dr. Jason Wong is a graduate of the Public Health and Preventive Medicine/Family Medicine residency program at UBC. He currently works as a Physician Epidemiologist at the BC Centre for Disease Control, responsible for the surveillance of HIV/STI, TB, and Hepatitis C.

Learning Objectives:
At the end of the session, participants will be able to:
1. Describe the rationale for HBV perinatal screening and when Hepatitis B testing is performed in pregnancy
2. Describe regional and demographic variations in perinatal HBV screening and infection
3. Discuss opportunities to improve HBV screening and documentation of infection within BC
“How Long Should I Wait?” A Panel Discussion Reviewing Current Evidence and Best Practice to Support Optimal Inter-Pregnancy Intervals for Older Mothers  
Wendy Norman, Mani Asgharpour, Laura Schummers, Dorothy Shaw

Abstract

Background: Delayed childbearing poses important challenges for planning the spacing of a woman’s pregnancies. Older mothers are increasingly common. In 2013, 15% of babies in the US were born to women over 35 and 3% to women over 40, a dramatic increase from only 8% and 1% in 1988. Pregnancies are at increased risk for adverse outcomes as maternal age increases, and yet inter-pregnancy intervals <12 months are associated with increased risks also. The optimal inter-pregnancy interval for women who delayed their first pregnancy has not been identified.

Methods: We performed a systematic literature review of studies seeking to establish the relationship between inter-pregnancy interval and adverse maternal or perinatal health outcomes in women who delayed childbearing to 30 years or older in the setting of high-resource countries. Additionally, we have developed the methodology and conducted preliminary analyses for ongoing research examining the relation of inter-pregnancy interval to maternal and perinatal health outcomes following a first birth over age 30 in British Columbia using the BC Perinatal Database Registry.

Results: Panelists will review findings of the Systematic Review, the current analysis of outcomes in BC, and best clinical practices to support appropriate inter-pregnancy interval timing, followed by interactive audience discussion with interdisciplinary panel members.

Conclusion: Attendees will leave with a better knowledge base to inform decision-making with mothers over 30 planning a subsequent pregnancy.

Biographies

Dr. Wendy Norman holds the CIHR Chair in Family Planning Public Health Research and is an Associate Professor in the Department of Family Practice at UBC. She leads Canada’s national network, the Contraception Access Research Team, aiming to generate evidence that will enable women to equitably access the knowledge, services and methods they need to achieve to time and space their pregnancies.

Mani Asgharpour is an international medical graduate and volunteer research assistant with the Contraception Access Research Team of the Women’s Health Research Institute at BC Women’s Hospital.

Laura Schummers is a Doctoral candidate in Epidemiology at the T.H. Chan Harvard School of Public Health. Her research aims to understand optimal obstetrical care for low-risk mothers and babies. She holds a BSc in Global Resource System from UBC, a MSc from Harvard, and has worked as a Research Manager in the UBC Midwifery Program. Her Doctoral studies are supported by a training grant in reproductive and perinatal epidemiology from the National Institutes of Health.
Dr. Dorothy Shaw is the Vice President of Medical Affairs at BC Women’s Hospital and Health Centre, a Clinical Professor at UBC, and a past president of the International Federation of Obstetrics and Gynecology, FIGO, as well as of the Canadian Society of Obstetricians and Gynecologists. She has numerous national and international academic and advocacy awards reflecting her very successful lifelong passion to support women’s health and healthy families.

**Learning Objectives**

1. Review current recommendations and new research on optimal inter-pregnancy intervals, particularly for mothers over age 30 at the time of birth
2. Reflect on clinical best practices to assist mothers over age thirty to space their pregnancies appropriately
3. Participants will be able to integrate the new knowledge presented on inter-pregnancy interval best practices by engaging in dialogue with panel experts and health care professionals from a range of disciplines
Interpregnancy Intervals and Infant Outcomes: Does Matching Two Intervals in the Same Mother Change the Associated Risks?

Gillian Hanley

Authors
Gillian Hanley
Jennifer Hutcheon
Lily Lee
Brooke Kinniburgh

Abstract
There is evidence suggesting that the time interval between pregnancies can be an important and potentially modifiable risk factor for adverse birth outcomes. Short intervals between a live birth and a subsequent conception (less than 12 months), as well as very long intervals (more than 23 months) have been associated with increased risk for preterm birth, low birth weight, small-for-gestational age birth, admission to the NICU, and even congenital anomaly. While the causal mechanism of interpregnancy interval on outcomes has been a source of considerable debate, the ‘maternal depletion hypothesis’ proposes that mothers with short intervals insufficiently recover physiologically between pregnancies, while long interpregnancy intervals result in women gradually losing the physiological adaptation to pregnancy.

The alternative hypothesis is that the intervals are not causal and that the outcomes are instead related to maternal factors that are correlated with interpregnancy interval and the birth outcomes in question, including such things as socioeconomic status, demographics, and lifestyle. Many of these confounders are difficult to adequately control for in empirical research. Thus, to further examine the alternative hypothesis that interpregnancy interval may be confounded, we examined interpregnancy intervals among the same mother who gave birth 3 or more times in BC between 2000 and 2014 in an attempt to determine whether variation in birth outcomes might be explained by risk factors that vary greatly between women but tend to persist among the same woman between pregnancies.

Learning Objectives
At the end of the session, participants will be able to:
1. Summarize the relevant evidence on interpregnancy intervals;
2. Identify confounders between interpregnancy interval and infant outcomes that may vary greatly between women but persist among women across pregnancies;
3. Understand the relative risks associated with short and long interpregnancy intervals when comparing across different women, and how these relative risks change when comparing within the same woman across pregnancies.
Dr. John Pawlovich provides full time primary care for a number of remote Carrier communities in north central BC through monthly in-community visits that are supported by telehealth. Many of these communities have never had physician coverage, or have had it sporadically, and patients have previously needed to travel, sometimes up to four hours driving on logging roads, to reach care. Although technology plays a large role in supporting the telehealth visits, Dr. Pawlovich also uses technology to supplement in-community visits. One example is the use of a bedside ultrasound machine used to show pregnant women their babies during prenatal visits. Anecdotally, we had noted a very positive response to this experience, but in an age of evidence-based medicine, felt this deserved more thorough investigation. Community engagement and community-led investigations are crucial to research in First Nations communities. The results that we will present are preliminary findings that were obtained through community meetings and individual interviews to explore the communities’ priorities with regard to research and health interventions. Our results include preliminary themes related to the experience of ultrasound, as well as input with regard to study design. This presentation will include first-hand accounts from community members.

**Learning Objectives**

1. Discuss a newly accessible technology that has the potential to enhance prenatal care in remote settings
2. Review basic indigenous methodological research principles, and the importance of community input for research endeavors
3. Present preliminary findings that may guide the implementation of an in-depth qualitative research project, and begin to guide the use of bedside ultrasound as a clinical tool
Abstract

In 2008 BC Corrections announced that a mother child unit in Alouette Correctional Centre for Women would close. In 2013 the Supreme Court of British Columbia ruled that “the decision to cancel the Mother Baby Program was arbitrary, overbroad and grossly disproportionate and therefore contrary to the principles of fundamental justice.” Judge Ross also noted that the closure of this unit infringed the constitutional rights of mothers and babies. Dr. Elwood Martin and Dr. Granger-Brown were both witnesses at this trial having worked with the mothers and babies in the prison.

Subsequent to this decision the CCPHE facilitated a meeting with representatives from 40 Canadian organizations with delegates from USA and New Zealand. The development of this internationally unique document was collaborative over two days of meetings at the University of British Columbia and afterwards with multiple rounds for editing and input by all attendees. These are basic principles of care that are required for optimal child and maternal health specifically developed for the correctional context, during pregnancy, birth, and the first two years of life. One section concerns maternal education, and correctional and medical care. Discharge planning and community partner engagement is also considered. The Guidelines describe the collaborative interdisciplinary, inter-agency approach that is essential to promote stability and continuity for mother-child health and bonding, building strong parental relationship in and beyond the correctional facility. The presentation will share insights and experience for care of this unique and vulnerable population both mothers and their babies and briefly outline the Guiding Principles in the document which will be available for participants at the session.

Biography

Alison Granger-Brown worked with people in prison both federal and provincial for 15 years and dedicated her master's degrees and PhD studies to understanding the healing beyond complex childhood trauma that so often brings people into addiction and then prison. Her research and passion is now focused on understanding and sharing the needs of children left behind, who become the invisible prisoners of shame, collaterally damaged by “justice”. She was a witness in the Supreme Court Charter Challenge in 2013.

Learning Objectives

1. Increase knowledge of the unique and vulnerable population of mothers in prison
2. Familiarize attendees with the Guiding Principles for Mother Child Units
3. Share the success of such units internationally and in Canada
A Paradigm Shift: Island Health is Changing the Way Public Health Nursing Provides Care to Women and Families during Pregnancy and Parenting by Adopting the Nuu-chah-nulth Nursing Program’s Mother’s Story Approach to Care

Erin O’Sullivan, Liz McKay, Jan Tatlock

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Abstract

In BC, recent direction for Public Health is emphasizing top of scope practice, guided by best practices that, with confidence and competence, intentionally place priority populations at the centre of care. Public Health Nursing is positioned to offer health promotion, education, referral, and intervention with a practice focused on inviting women with heightened exposure to risks due to social vulnerabilities into a care relationship. Island Health’s quality improvement strategy to shift the Public Health practice approach is underway. This practice shift will occur through the adoption of the Mother’s Story—the Nuu-chah-nulth Nursing Program’s approach of providing culturally safe, trauma-informed, relational, and reflective practice care to pregnant and parenting women. The approach is based on a positive and caring relationship between the mother/family and the nurse, which facilitates trust, collaboration, teaching, and support in a respectful manner specific to the woman’s journey. The Mother’s Story is made possible through the vision of Island Health’s Public Health Director and our relationship with the Nuu-chah-nulth Tribal Council.

The Mother’s Story approach to care meets the standards set by Perinatal Services BC’s provincial perinatal pre and postnatal care pathways. The intention of the presentation is to complement the aforementioned standards by applying awareness of the saliency and value of strengths-based leadership to the action plans and evaluation processes of adopting the Mother’s Story approach to care. Island Health recognizes that strengths-based leaders are integral to role-modeling change and in mentoring nurses to practice the Mother’s Story approach. Island Health leaders have supported nurses to transition from previous ways of practicing, accounted for and worked through resistance, and has created supportive environments for nurses to successfully practice in a relational and respectful way. This presentation will include time for dialogue on the experiences of engaging in this paradigm shift in practice.

Biographies

Erin O’Sullivan’s nursing career is defined by a passion for developing, implementing and evaluating best practice standards for perinatal health programs and building practice capacity to meet those standards within the uniqueness of communities. Erin is currently working for Island Health as the Perinatal Program Development and Evaluation Lead. Erin believes that supporting professionals to feel confident in an approach to care that is underpinned by a belief that women are the experts of their lives will change the way care is delivered and received.

Liz McKay’s nursing career and passion has focused on supporting Aboriginal women and families during pregnancy and parenting. She has worked with the Nuu-chah-nulth Tribal Council’s Community Health Nursing Program, Nuu-chah-nulth women and Elders to provide care based on the Mother’s Story—a culturally safe, trauma-informed, relational, and reflective practice approach to care. Liz is currently working with Island Health to assist public health nursing in adapting the Mother’s Story to be delivered to all pregnant women seeking enhanced support during pregnancy and parenting. One of Liz’s favourite quotes by Henri Nowen is “To prepare ourselves for service we have to prepare ourselves for an articulate not “knowing”, a docta ignoritia, a learned ignorance”. Liz values this quote
as it allows for space to hear women’s stories and the impact it has on their life experiences, hopes and dreams for themselves and families.

**Learning Objectives**

1. Become aware of an innovative care delivery model—the Mother’s Story—for supporting pregnant, birthing, and parenting women from a critical social theory lens

2. Learn about the challenges/benefits of supporting a change in Public Health nursing practice, specifically the shift from “doing for” to “doing with” women and their experiences of public health support

3. Be aware of the supports necessary for nurses to successfully practice the Mother’s Story
Abstract

Background: Many Canadian programs and services are gaining attention for their successes in using a harm reduction approach to engage pregnant women who use substances, improving women's health, and ensuring that women and their babies have the best possible start in life.

Methods: An academic and grey literature review of research related to harm reduction and pregnancy was conducted. Through collaboration with five harm reduction-oriented maternity programs in Western Canada, training materials for health care and social service providers were developed, including a summary of best and promising practices, information sheets on substance use during pregnancy, and a “Small Steps Matter” poster for women struggling with substance misuse and addiction concerns.

Results: Resources will be introduced that can inform the practice of service providers who may be interested in incorporating or expanding their use of harm reduction approaches when working with pregnancy women with substance use concerns.

Conclusion: There is evidence to support the use of a range of harm reduction-based interventions to effectively promote a healthy pregnancy as well as encourage reducing or stopping substance use during pregnancy.

Biographies

Tasnim Nathoo, MSc, MSW, RSW, is a Knowledge Translation consultant with the BC Centre of Excellence for Women’s Health. She has been involved in a number of projects at the Centre related to alcohol and pregnancy, trauma-informed practice in mental health and addiction services, and health promotion for girls and young women. She is the co-author of The One Best Way? Breastfeeding History, Politics, and Policy in Canada (2009).

Learning Objectives

1. Provide an introduction to harm reduction approaches during pregnancy
2. Review the evidence base for a range of harm reduction-based interventions
3. Use examples from integrated maternity care or “one-stop shop” programs across Canada to illustrate harm reduction ‘in action’
Plenary  The Biology of Loss: Recognizing the Consequences of Impaired Attachments and Fostering Resilience

Gabor Maté
Qualitative Interviews with Parents of Babies and Young Children with Cleft Lip and Palate

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Abstract
Background: Diagnosis of children with cleft lip and palate occurs antenatally (usual for cleft lip) and at birth (for isolated cleft palate). This condition impacts upon aesthetics, feeding and speech. Diagnosis portends a series of medical interventions extending from infancy into adult life. Patient-reported outcomes have been explored in older children with cleft, but the experience of parents of younger children has not previously been studied.

Objective: To better understand the experiences, challenges and adaptations of parents with children who have cleft lip and/or palate.

Methods: In-depth semi-structured interviews with parents of children aged 0-7 years with cleft lip and/or palate. Interviews were recorded, transcribed, and analyzed using NVivo software. Analysis was by open coding of transcripts. Emergent themes were organized into a conceptual framework. Key strategies to improve care were identified.

Results: Fourteen interviews were conducted: 3 were with both parents; 11 were with the mother only. Major themes in the conceptual framework were: diagnosis, physiology and function, social interaction, experience of healthcare, and personal emotional. Within each theme, subthemes were identified.

Conclusion: Parents of children with cleft lip and/or palate experience many emotions. Awareness is the first step for clinicians to more fully support parents in their journey. Steps to optimizing care include improving parents’ access to good information, nurturing a caring attitude in health professionals and developing a peer support network. Parents were overwhelmingly keen to share their experiences in the hope of improving the experience for future families.

Biographies
Elly Breuning was a Clinical Fellow in Plastic Surgery at the BC Children’s Hospital from July 2014 - June 2015. Prior to this she did her Plastic Surgery training in the UK.

Learning Objectives
1. Understand the range of emotions experienced by parents on diagnosis of their child with cleft lip and palate
2. Understand the impact of the information given by the health care professional on the parent’s journey
Managing Depression: Resources to Support Women Living With Depression During Pregnancy, After Delivery and Beyond

Jo-Anne Robertson

Author
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Health Promotion Consultant
Best Start Resource Centre

Abstract
Two resources were created to support women living with depression during pregnancy, after birth and beyond. The first resource is a self-help resource that women can use on their own or with a service provider to improve their mental health. Strategies include cognitive behavioural techniques (how to reactive your life, thinking realistically, solving problems effectively and reducing the risk of relapse) and health promotion strategies (eating well, being active, getting enough sleep). The facilitator’s guide is a companion document to facilitate groups based on the self-help resource. The facilitator’s guide contains activity plans, activities and lists of resources to facilitate five 2-hour sessions.

These resources can be used with women who have PMD including those who are not formally diagnosed. The health promotion focus of the resources helps women to achieve good mental health while living with the mental illness of depression. Groups have been delivered to community populations by public health nurses with positive feedback from participants and an improvement in Edinburgh Postnatal Depression Scale results during focus testing. These resources will prove valuable tools for health care providers and public health personnel who support women living with depression during the perinatal period and beyond.

Learning Objectives
1. Understand how to support the well-being of pregnant and parenting women who live with depression in one-on-one or group settings
2. Develop skills in facilitating a skills-based group for pregnant and parenting women who live with depression
3. Use evidence-based interventions such as healthy lifestyle behaviours, building support systems, and cognitive behavioural skills to help pregnant and parenting women living with depression to manage and reduce symptoms, prevent reoccurrence and promote mental health
To address the call by the Ontario Health Kids Panel for consistent prenatal education messaging as one of the strategies to reduce childhood obesity, Best Start Resource Centre has developed a web-based tool with prenatal education key messages accompanied by supporting evidence and relevant resources and references.

Preliminary research indicated that although 96% of expectant and new Ontario parents surveyed in 2014 indicated that they feel prenatal education is useful, only 49.5% felt that it was a trustworthy source of information. A national scan also indicated that only 5 of the 11 Provinces and Territories contacted had a provincial/territorial body, provincial resource or provincial strategy related to prenatal education.

A web-based tool developed to provide current, evidence-based key messages for prenatal education providers in Ontario has the potential to help build credibility of prenatal education programs in hospital, public health and private settings. By highlighting background research, demonstrating the web-based tool and sharing evaluation and sustainability strategies, attendees will be able to navigate the tool and use the prenatal education key messages in their practice as appropriate. In addition, attendees will be challenged to advocate for similar provincial prenatal education strategies and to promote consistency in prenatal education information provided to families.

With a central source of credible information, it will make it easier for all providers of prenatal education information to provide their clients with up to date, evidence-based prenatal education, whether in a traditional prenatal class, or in a variety of other settings.

**Learning Objectives**

1. Understand the rationale for using consistent, current evidence-based key messages when providing prenatal education/information in all settings.
2. Become familiar with the Prenatal Education Key Messages for Ontario web-based tool and explore ways in which it can be integrated into participants’ current practice.
P4 Health Care Providers’ Perceptions of the Barriers and Facilitators to Supporting Women to Achieve Guideline Concordant Gestational Weight Gain

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Abstract
Background: Appropriate gestational weight gain (GWG) is a topic of emerging importance in prenatal care. In a recent cohort of pregnant women in Alberta, 56% gained weight in excess of Health Canada guidelines. Despite this, Canadian studies have shown low rates of GWG counselling by healthcare providers (HCPs). The purpose of this study was to explore HCP perceptions of the barriers and facilitators to addressing GWG with women.

Methods: Semi-structured interviews were conducted to the point of theoretical saturation with HCPs across Alberta and British Columbia (n=23). A variety of HCP disciplines were sampled in urban and rural areas of each health zone. Interviews were transcribed verbatim, and analyzed using qualitative content analysis.

Results: HCPs reported initiating discussions about GWG with women; however, the extent to which weight was discussed at subsequent visits varied. HCPs reported barriers at the individual level when addressing GWG in the healthcare setting, including the sensitive nature of the topic, and lack of time in a typical appointment. Barriers at the healthcare system level included compensation methods for physicians, and accessing dietitian services. Facilitators included access to a multidisciplinary team, and compensation methods that allow flexibility in the time and topics covered in appointments.

Conclusions: Discussions about GWG may not be occurring as in depth or as frequently as needed to support women to achieve guideline concordant GWG. This may be due to barriers at the individual and healthcare system level. HCPs have identified opportunities for improvements in healthcare system processes to support healthy GWG.

Biographies
Jill graduated from the University of Alberta’s Integrated Dietetic Internship in 2010, and has since worked as a public health dietitian with Alberta Health Services. She began her Masters of Science in Nutrition and Metabolism in 2014 under the supervision of Dr. Rhonda Bell. Jill’s research uses mixed methods to explore opportunities to support health care providers in promoting optimal nutrition and weights in pregnancy and postpartum.
Restrictive Palivizumab for Infants Born at 29 to 31+6/7 Weeks Gestation

Brandi Newby, Todd Sorokan

Abstract

Background/Rationale: Immunoprophylaxis with palivizumab can lead to reduced respiratory syncytial virus (RSV) related infections and hospitalizations. The criteria in British Columbia (BC) restrict the use of palivizumab in infants born at 29 to 31+6/7 weeks gestation, which differs from the American Academy of Pediatrics (AAP) and Canadian Paediatric Society (CPS) guidelines. The objective was to determine if the BC criteria had an effect on the frequency of RSV positive results for our population of infants.

Methods: Databases were generated from May 1, 2008 to April 30, 2011 for: infants born in or transferred to the Fraser Health Authority with a gestational age of 29 to 31+6/7 weeks, RSV positive results for infants less than 12 months, and palivizumab approval. Infants were matched across databases using their personal health number.

Results: There were 359 infants born at 29 to 31+6/7 weeks. With the BC criteria, 46 of the 297 AAP/CPS candidates received approval for palivizumab. Sixteen infants (4.5%) were RSV positive during RSV prophylaxis months. Of infants that received approval for palivizumab, 4.3% were RSV positive, and of those not approved, 5.6% were RSV positive. Of the 359 infants, six (1.7%) were RSV positive while admitted to the NICU, and 10 (2.8%) were readmitted to hospital.

Conclusions: RSV positive frequency was not different between infants that received or did not receive approval for palivizumab in Fraser Health. Therefore, a risk factor based approach for RSV prophylaxis of infants born at 29 to 31+6/7 weeks warrants further investigation.

Biographies

Brandi Newby is a clinical pharmacy specialist in neonatal intensive care in Fraser Health. She was curious about the rapidly changing guidelines for RSV prophylaxis and the outcomes for the patients.

Dr S. Todd Sorokan is a Pediatrician/Neonatologist in FHA for 15 years and clinical associate professor UBC. He has been interested in RSV prophylaxis for many years and has always felt that we need more data on the subject to make informed decisions on its use.

Learning Objectives

1. Review and compare national and international RSV prophylaxis guidelines to BC criteria at time of study
2. Discuss if the BC criteria had an effect on the frequency of RSV positive results for our population of infants
Review of Neonatal Intensive Care Admissions Following Cesarean Section

Brandi Newby, Hilary Rowe, Jason Burrows, Rebecca Sherlock

Abstract

Background/rationale: Corticosteroids administered antenatally may be beneficial in reducing admission to the Neonatal Intensive Care Unit (NICU) for short-term respiratory morbidity in term neonates born via cesarean section. However, admission to the NICU for non-respiratory indications and the long-term potential consequences of corticosteroids in this population are not known. So, the main objective was to determine the frequency and reasons for admission to the NICU following cesarean section for neonates born at or near term gestation.

Methods: Chart reviews were completed for all women who had a cesarean section at 35 or more weeks gestation at Surrey Memorial Hospital (SMH) in 2013. The charts of their neonates were also reviewed. Information was collected in regards to risk factors for NICU admission, as well as the details of the NICU admission.

Results: There were 1479 women who had a cesarean section at 35 weeks or more gestation in 2013, with 150 (10.1%) of their neonates being admitted to the NICU. Reasons for admission included respiratory distress alone (~0.6%), respiratory distress with other indications (~4.4%), and other non-respiratory indications (~5.1%). For women who had an elective cesarean section, 3 (~0.6%) of their neonates were admitted to the NICU for respiratory distress alone.

Conclusions: Admission to the NICU for respiratory distress alone occurred at a very low frequency in our population. Therefore, the potential benefit of administering routine corticosteroids antenatally to women undergoing cesarean section at term gestation does not currently appear to outweigh the potential risks and costs of the medication.

Biographies

Brandi Newby is a clinical pharmacy specialist in neonatal intensive care at Surrey Memorial Hospital. She completed her Pharmacy Degree at the University of Alberta, and residency at Alberta Children’s Hospital. Her main focus of research is medication use in the NICU.

Dr. Hilary Rowe is a Clinical Pharmacy Specialist in Maternal Fetal Medicine at Surrey Memorial Hospital and is the co-author of Medications and Mothers’ Milk, a reference for medication use in lactation. Dr. Rowe obtained her Bachelor of Science in Pharmacy and Doctor of Pharmacy Degrees at the University of British Columbia in 2009 and 2012, respectively and her hospital residency with the Vancouver Island Health Authority in 2010.

Dr. Jason Burrows is a Maternal Fetal Medicine Specialist with joint appointment in Fraser Health and BC Women’s Hospital. His role is to provide complex obstetrical care from both a maternal and fetal perspective. He serves as a Regional Division Head for Obstetrics in Fraser Health and oversees quality assurance, clinical practice, education and research initiatives in the region. He received his MD and residency in Obstetrics and Gynecology from UBC and completed a Maternal Fetal Medicine fellowship and Dalhousie.

Dr. Rebecca Sherlock is Neonatologist at Surrey Memorial Hospital and Clinical Assistant Professor at UBC. She completed a BSc (Biology) at Queen’s University, her MD at Memorial University, a Pediatrician and Neonatal-Perinatal Medicine Fellowship at Univ of Ottawa, a Neonatology Fellowship at the Royal Women’s Hospital in Melbourne Australia and a Master’s of Health Science at UBC. Her main focus of research is respiratory support modes and respiratory comorbidities in neonates.
**Learning Objectives**

1. Discuss one potential benefit and three potential risks of steroid administration in term women undergoing elective cesarean section

2. Describe the current rate of admission to the NICU for respiratory distress alone, respiratory distress with other indications, and other non-respiratory indications
P7 7 Generations: Examining Gestational Diabetes and High Glucose during Pregnancy within Indigenous Communities
Ashley Lamothe, Kim Lamothe

Author #1
Ashley Lamothe
Gestational Diabetes Prevention Coordinator
Southern Ontario Aboriginal Diabetes Initiative

Abstract
Gestational Diabetes is a form of glucose intolerance during pregnancy which affects Indigenous women at a higher rate than the average Canadian (4% of Canadian pregnancies versus 18% of Indigenous pregnancies). High glucose is the higher than average rates of glucose in the bloodstream prior and after the Oral Glucose Tolerance Test.

Indigenous women are also at higher risk of prenatal complications due to high prenatal glucose. The Southern Ontario Aboriginal Diabetes Initiative (SOADI) is a non-profit organization with the goal of reducing the staggering rates of diabetes in Southern Ontario through prevention and management, including Gestational Diabetes. In 2014 SOADI created the 7 Generations Gestational Diabetes Prevention Program with the goals of:

- Raise awareness of Gestational diabetes and Prenatal High Glucose separate from Type 1 and Type 2
- Education of Front Line Workers on incorporating GDM and PHG into regular prenatal programming
- Encourage Indigenous based content and education

This is being accomplished through resource development and Front Line Worker coaching. In amalgamating medically necessary information with traditional knowledge, 7 Generations has been able to develop a solid base of cultural programming and increased awareness to Indigenous communities. Future pre, peri and postnatal programs with focus on GDM prevention are needed to reduce high glucose during pregnancy thus reducing risks of complications to both mother and fetus.

Biographies
Ashley Lamothe is an Ojibway woman from Southern Ontario. She attended post secondary at the University of Lethbridge and earned a degree in health sciences. She has been employed with SOADI for the past 6 years and has been involved in the Gestational diabetes prevention program since its pilot. She is a mother of 2 and aunt to many.

Kim Lamothe is a proud mother, grandmother, daughter, sister, auntie and friend to many across Turtle Island. Kim was born in Winnipeg, Manitoba and lived with her grandparents in Geraldton, Ontario. She is from the turtle clan and is mixed blood, Ojibway and Metis descent, from Northwestern Ontario, Longlac #58. She has been educated in various fields and holds an Honours BA from Trent University, B.Ed from Nipissing. Her educational background and life experiences has created the strong desire she has to promote health and wellness across Turtle Island through various cultural teachings and educational opportunities. She currently lives in the City of Thorold and is employed with SOADI as the Traditional Knowledge Coordinator.

Learning Objectives
1. Accurate understanding of impact of high glucose within Indigenous pregnancies
2. Increased awareness of unique needs of Indigenous families pre, peri and postnatal
Abstract
The Public Health Agency of Canada (PHAC) continues to inform maternal and newborn health professionals of ongoing revisions to the Family-Centred Maternity and Newborn Care National Guidelines (FCMNC Guidelines).

Canadian national guidelines for maternal and newborn care have been published since 1968. By 1987 the principle of family-centred care and the importance of an inclusive approach became widely recognized and resulted in changes to the FCMNC Guidelines. A needs assessment conducted in 2012 by the Society of Obstetricians and Gynaecologists determined the need for updates, stakeholder interest, new content information and content contributors. The updated FCMNC Guidelines will be enriched by new evidence and updates in practices and technology.

An Oversight Committee representing key maternal and child health stakeholders oversees the revisions. Over 30 key stakeholder organizations will participate in an endorsement process for the revised FCMNC Guidelines.

The revision is currently underway and chapters will be released electronically as they are completed. Key areas of research and updated evidence include:

- Guiding Principles
- Organization of Services, Transport and Facilities and Equipment
- Preconception Care
- Care During Pregnancy
- Care During Labour and Birth
- Early Postpartum Care of Mother & Infant, Transition to Community
- Breastfeeding
- Loss and Grief
- Future Directions

Biographies
Kristin Bennett is a Policy Analyst with the Division of Children, Seniors and Healthy Development at the Public Health Agency of Canada. She has a background in nutrition and a master’s degree in Public Health specializing in Global Health. She has held a variety of positions focusing on the health of vulnerable populations.

Learning Objectives
1. Increase awareness of the FCMNC Guidelines and timely revision process
2. Understand the importance of multi-disciplinary family-centred care and guiding principles related to maternity and newborn care
3. Release available updated chapters and introduction/guiding principles
Abstract

Background: Interior Health (IH) offers comprehensive in-person prenatal education to a geographically dispersed population. A regional review of prenatal services identified a need to engage pregnant women who are unable to access existing prenatal education. Use of technology to expand access was recommended. The purpose of this project was to conduct an environmental scan of available web-based prenatal curricula in Canada to inform IH’s planned expansion of prenatal education services.

Methods: Government websites were reviewed to determine in which Canadian jurisdictions online prenatal education is offered. Specific health authority webpages within a province or territory were assessed and representatives were contacted for further information on programs. Curricula were compared on characteristics such as scope of material, content sources, target population, literacy level, languages offered, customization capabilities, Baby-Friendly Initiative certification, and cost.

Results: Web-based prenatal education is currently offered in Alberta, Saskatchewan, Ontario, Québec New Brunswick and Nova Scotia. Four main programs were identified: A New Life, Welcome to Parenting, The Gift of Motherhood, and Understanding Birth eClass. While all curricula offer prenatal education, the depth of information provided varies for the postpartum period, parenting, relationships, and target population. Formal evaluations of program effectiveness are limited.

Conclusion: Several online prenatal education programs are currently used across Canada, each selected to meet specific jurisdictional needs and objectives. Results of this environmental scan are informing IH’s understanding of online education and its potential as a relevant, accessible and practical form of prenatal curricula for the southern interior population of BC.

Biographies

Megan attained a BSc from Brock University in 2012. She worked as the Director of Public Relations for Perinatal Mood Disorder Awareness Ltd from May 2013 to November 2014 where she developed a passion for maternal and child health. Megan completed her practicum with Interior Health developing a summary on the availability and effectiveness of online prenatal education and will receive her MPH from the University of New England in Sept 2015.
Learning Objectives

1. Understand the availability of online prenatal education programs in Canada for expectant mothers and their partners
2. Compare the characteristics of existing online prenatal education programs in Canada in order to inform planning and implementation of prenatal curricula in other jurisdictions
Intensive Support of Women Who Have FASD and are Pregnant: Our Experience
Jennifer Collon, Wenda Bradley

Author
Jen Collon
FASSY – Outreach Support worker
FASSY

Abstract
We would like to do a poster presentation on our experience of supporting 3 women who have FASD and had become pregnant.

We recognized this past year the gap in services for intensive support within the Yukon for women who have FASD and become pregnant. The need they have for a high level of support to become sober, maintain sobriety and care for their newborn infants. We would provide information on a strengths based approach we used through written notation, pictures and discussion - We may also do a small video that would run from the women's perspective.

We provided one support worker for the three women who then was able to assess needs, attend to needs and advocate on their behalf.

We have been successful for 2 women who are still caring for their infants and still receiving the intensive case support. We would discuss the difficulties of advocacy and the personal struggles the individuals had. We will also discuss the agencies needs, difficulties and successes and look at possible future interventions. Included will be some concerns for the needed systemic changes we feel are needed to enable more women to receive the care that works for people who are falling through the cracks and end up having infants removed from their care.

Biographies
Jen Collon has life experience in supporting individuals with a disability. She previously worked for Autism Yukon in creating inclusion opportunities within the community of Whitehorse, Yukon. She obtained a diploma from Yukon College as a Support worker and joined the FASSY team in January 2015.

Wenda Bradley is a Registered Nurse who worked as a Community Health Nurse for many years in rural Yukon settings before joining the FASSY team in 2006. She first worked as a FASSY outreach worker in a small FN community then as the senior outreach worker in Whitehorse and has recently has become the Executive Director of FASSY.

Learning Objectives
1. Understand the needs for intensive support by observation, assessment and interaction
2. Engage in discussion of needs for women who are pregnant, have FASD and in need of high level of support
Background: There is significant interest in the availability of timely access to health services for British Columbians living outside the densely populated Metro Vancouver region.

Methods: From the BC Perinatal Data Registry, we analyzed 20,938 hospital deliveries from 2012/13 for women living outside of Metro Vancouver. We created a network dataset using the Digital Road Atlas to estimate drive time based on distance, speed limit, road type, and turn delays. Service areas within 30/60/120 minutes of road travel from each hospital, and drive times of each client from her residential postal code to the delivery facility were calculated using ArcGIS Network Analyst.

Results: 20,670 (98.7%) delivery records were successfully geocoded. Two maps were created: one demonstrating the areas within 30/60/120 minutes of obstetric facilities outside of Metro Vancouver, and the other demonstrating the proportion of non-Metro Vancouver women travelling >60 minutes to their delivery hospital. Overall, 90% of women travelled <60 minutes to their delivery hospital, 5.3% travelled 60-119 minutes, and 4.5% of women travelled >=120 minutes. The proportion of women travelling <60 minutes ranged from 77.3% in Northeast to 97.8% in Southern Vancouver Island, and the proportion travelling >=120 minutes ranged from 0.2% in Fraser East to 16.7% in Northern Vancouver Island.

Conclusions: Approximately 10% of women living outside Metro Vancouver travelled at least 60 minutes to their delivery facility in 2012/13. This analysis will contribute to future planning of service delivery based on accessibility.

Biographies
Rita received her Masters in Public Health degree from the University of Toronto. Since 2013, she has worked as an epidemiologist in the Population and Public Health Program at the Provincial Health Services Authority. Rita provides epidemiological, methodological, and analytical expertise as well as experiences in public health applications of GIS technology to support a number of projects undertaken by the program focusing on the surveillance of chronic diseases and associated determinants.

Brooke holds a Masters in Public Health with a specialization in Maternal and Child Health. She has been an epidemiologist at Perinatal Services BC since 2011. Her key responsibilities include routine and special analyses, as well as leading reporting efforts including facility-specific indicators.

Learning Objectives
1. See how GIS analysis can assist with identification of service patterns and gaps
Clinicians’ Perspectives and Experiences Regarding Obstetrical Care of Women with Vulvodynia

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Abstract

Background/Rationale: Vulvodynia, or chronic vulvar pain, is a distressing health concern affecting approximately 16% of women (Harlow et al 2003). Affected women have unique obstetrical needs (Rosenbaum & Padoa, 2012); however, no research has assessed clinicians’ experiences providing obstetrical care for this population.

Methods: 140 clinicians (91 physicians, 49 midwives) completed a survey to assess frequency of contact with pregnant women with vulvodynia; comfort providing ante/intra/post-partum care for these women; belief that vulvodynia is an indication for elective cesarean surgery and frequency of making this recommendation; and how many patients strongly requested cesarean delivery.

Results: Most physicians (70.4%) saw patients with vulvodynia at least once a month or more. Clinicians who saw women with vulvodynia were most likely to see pregnant vulvodynia patients less than yearly (40.3%) or every 6-12 months (21.6%). Almost one-third (31.4%) were not comfortable managing ante/intra/post-partum care for these women, and 16.4% endorsed vulvodynia as an indication for elective cesarean surgery. Among respondents who provided obstetrical care for these women, 15.4% had recommended cesarean delivery; potential worsening of vulvar symptoms was the most common reason for this recommendation. Maternal cesarean requests were rare for the majority (62.4%) who provided obstetrical care for women with vulvodynia.

Conclusions: Over 31% of clinicians attending women with vulvodynia were not comfortable providing their obstetrical care. Despite infrequent maternal requests, a minority of clinicians believed vulvodynia is an indication for cesarean delivery and/or made that recommendation. Additional research and education is needed to provide optimal obstetric care to women with vulvodynia.

Biographies

Dr. Smith received her PhD in Clinical Psychology from Queen’s University and completed fellowship training at Massachusetts General Hospital/Harvard Medical School and the University of British Columbia. She is currently a Research Associate in the UBC Department of Obstetrics and Gynaecology. Dr. Smith’s research focuses primarily on vulvodynia, including the pregnancy and post-partum aspects.

Brooke holds a Masters in Public Health with a specialization in Maternal and Child Health. She has been an epidemiologist at Perinatal Services BC since 2011. Her key responsibilities include routine and special analyses, as well as leading reporting efforts including facility-specific indicators.

Learning Objectives

1. Document clinician discomfort with providing obstetrical care to women with vulvodynia.
2. Characterize clinicians’ beliefs and practices regarding mode of delivery in women with vulvodynia.
Abstract

Background/rationale: Many communities are reporting increases in the number of infants requiring NICU care due to prenatal exposure to opioids and other substances. There is limited evidence about trends in nursing practice for this population.

Methods: Cross-sectional descriptive survey

Results: Surveys were received from 62 participants, representing a 53% response rate. Practices were described related to the physical environment, screening, withdrawal scoring, non-pharmacological management, feeding, discharge planning, and team education and support. Key shifts in practice have occurred since 2002. These shifts include an increase in keeping mothers and infants together, integrating programs and services across hospital and community settings, having a clinical guideline in place, routine withdrawal scoring, and having awareness of community programs. Some decreases were noted in designated space and discharge meetings.

Conclusions: Clinical benchmarking is one approach for gathering information that may be used for planning purposes, developing guidelines, evaluating initiatives, monitoring changes in care, and improving care. Key shifts in practice are occurring for this population. These findings provide a foundation for NICU teams to reflect on and improve their policies and practices within the context of their own community.

Biographies

Tara is an Educator in the Neonatal Intensive Care Specialty Nursing Program at the British Columbia Institute of Technology. Part of this study was conducted as her thesis during her MN program at the University of Victoria.

Lenora is an Associate Professor in the School of Nursing at the University of Victoria. She has practiced in the field of maternal-infant nursing since 1986, as a staff nurse, educator, administrator and researcher.

Shannon is the Coordinator of the Neonatal Intensive Care Unit Follow Up Program at the Victoria General Hospital in Island Health.

Learning Objectives

1. Describe current nursing care practices for infants with prenatal substance exposure
2. Compare these findings to an earlier Canadian survey (2002) and identify shifts in nursing practice that have occurred during this time
The Partners in Pregnancy Clinic:
Innovative Health Care within Ontario’s Family Health Team Model
Tracy Condon, Laura Koekkoek

Author
Tracy Condon
Social Worker
The Partners In Pregnancy Clinic

Abstract
As we all work to provide the best care possible for our clients, have you ever wondered about how to do more with limited time and budgets? This presentation will outline creative community partnerships between the Partners In Pregnancy Clinic (PIPC) and community agencies in Peterborough, Ontario. It will describe both the successes and trials and tribulations that we have encountered and will help to get your creative juices flowing about possible partnerships in your own community.

PIPC opened in Peterborough in 2008. To my knowledge, it is the only family health team of its kind in Ontario focused on pregnancy. We currently have seven family physicians doing prenatal care, along with a multi-disciplinary team with various qualifications. All of our clients are pregnant or up to six weeks post-partum. Patients come to us by referral either through their family physician or self-referral. We have a good reputation in the community with more psychosocially high-risk patients, but we do see a wide variety of pregnant women. In order to better serve our diverse population, we have partnered with key community agencies to be able to reduce barriers to care, and to offer our clients more services.

Examples of our partnerships include: partnering with the local School For Young Moms to run groups, working with a local pediatrician to create a pathway to care for pregnant women using methadone and finally partnering with the local early years centre to run a social support group for new moms.

Biography
Tracy Condon, MSW, RSW is a Social Worker at the Partners in Pregnancy Clinic in Peterborough, Ontario. The Partners in Pregnancy Clinic is a Family Health Team that has been operating since July 2008, and Tracy was been working there since the beginning. She has been practicing as a Social Worker in the Peterborough area for the past 12 years and her other areas of expertise include school board social work and child welfare. Prior to obtaining her MSW from the University of Toronto, Tracy completed an undergraduate degree in psychology and sociology from Trent. She is passionate about community partnerships and working together to better utilize time and skills for clients.
**Abstract**

Background: Aiming to address health inequities, biomedical research has overwhelmingly focused on racialized groups ‘divergent’ infant feeding practices as an explanation for extant demographic disparities. The implicit assumption is that racial/ethnic minorities and/or immigrant mothers’ breastfeeding practices are in need of investigation rather than the assumptions and practices of health care providers regarding diverse mothers.

Current practices vs. proposed changes: My ethnographic research examines how professional practices of public health nurses in urban, western Canada contribute to the racialization of ‘Chinese’ mothers during the postpartum period. My aim is to engage health practitioners in understanding the processes, practices, and protocols that reify racialized categories.

Results: My findings demonstrate that public health nurses attempt to negotiate the sticky terrain of providing ‘culturally competent’ and ‘population-specific’ breastfeeding support for mothers understood as having ‘barriers’ to successful breastfeeding. As a result, my analysis illustrates that getting caught up in ‘cultural’ explanations can racialize postpartum mothers by reading them as different than ‘White’ Canadian society.

Implication for Practice: I argue that professional nursing praxis conflates, creates, and maintains concepts of ethnicity, race, and culture in public health nursing contexts and that those categories of difference can contribute to the differential support, protection, and promotion of breastfeeding.

**Biographies**

Alysha McFadden is a public health nurse who has worked in Vancouver, Whitehorse, and Haiti. Alysha completed her Master of Science degree at Simon Fraser University in the Faculty of Health Sciences. From these diverse experiences, Alysha has developed unique perspectives on global, and local, health disparities and inequities which continue to inform her clinical practice and research interests. Her goal is to improve public and population health programs and services.

**Learning Objectives**

1. Explore your initial thoughts and feelings, through contemplation, journaling, discussion, and/or doodling, regarding the information presented in this topic
Diagnosing Onset of Labor:
A Systematic Review of Definitions in the Research Literature
Patricia Janssen

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Abstract
Background: The diagnosis of labor onset has been described as one of the most important judgments in maternity care. There is compelling evidence that the duration of both latent and active phase labor are clinically important and require consistent approaches to measurement. To measure the duration of labor phases systematically, we need standard definitions of their onset. We reviewed the literature to examine definitions of labor onset and their evidentiary basis.

Methods: Five electronic databases were searched using predefined search terms. We included English, French and German language studies published between January 1978 and March 2014 defining the onset of latent labor and/or active labor in a population of healthy women with term births. Studies focusing exclusively on induced labor were excluded.

Results: We included 62 studies. Four types of labor onset were defined: latent phase, active phase, first stage and unspecified. Labor onset was most commonly defined through the presence of regular painful contractions (73% of studies) and/or some measure of cervical dilation (61% of studies). However, there was considerable discrepancy about what constituted onset of labor even within type of labor onset. The majority of studies did not provide evidentiary support for their choice of definition of labor onset.

Conclusions: There is little consensus regarding definitions of labor onset in the research literature. In order to avoid misdiagnosis of the onset of labor and identify departures from normal labor trajectories a consistent and measurable definition of labor onset for each phase and stage is essential. In choosing standard definitions, the consequences of their use on rates of maternal and fetal morbidity must also be examined.

Biographies
Dr. Janssen is a Professor and Co-theme Leader, Maternal Child Health in the School of Population and Public Health at UBC and Associate Faculty in the Departments of Family Practice, Midwifery and Obstetrics and Gynecology. She teaches a graduate course in perinatal epidemiology. She undertakes clinical trials to evaluate aspects of clinical care during the perinatal period and utilizes population data in BC to evaluate outcomes and costs associated with models of maternity care.

Learning Objectives
1. Understand definitions of labor onset used in the research literature
2. Learn limitations of current definitions for use in clinical decision-making and research
3. Discuss new directions for diagnosis of latent and active phase labour onset
Abstract

Background
Among high resource countries, incidence of preterm birth and low birthweight differ for women of low versus high socioeconomic position. We undertook a systematic review of the literature to determine if, in high resource countries, midwifery clients of low socioeconomic position were at less risk of adverse infant birth outcomes compared to physicians’ patients.

Methods
Reviewers identified 917 records in a search of 12 databases, the grey literature, and citation lists. Titles and abstracts were screened for 753 documents with 31 full documents assessed and 10 studies found to meet inclusion criteria. Quality assessment by two raters per study, using a standardized tool, resulted in eight studies receiving moderate quality ratings, two exclusions due to weak quality, and no studies receiving a strong rating. Data were extracted, then verified by a second reviewer and results synthesized narratively.

Results
The results suggest that midwifery care is at least as effective as physician-led care for vulnerable women; that it is associated with an increase in mean birthweight by 43g to 191g (p<0.05) (3 studies), and lowers the risk of very low birth weight by 65% to 68% (AOR=0.35, 95% CI: 0.1,0.9; RR=0.32, 95% CI: 0.16,0.63) (2 studies), preterm birth by 30% (AOR=0.70, p<0.01), and decreases stays (1 to 3 days) in NICU (ARD=-1.8 95% CI: -3.9,0.2).

Conclusion
In low socioeconomic clients, midwifery care is associated with improved, or comparable, perinatal outcomes as physician-led care. Aspects of midwifery care that promote improved outcomes need to be further elucidated in future studies.

Biographies
Dr. Janssen is a Professor and Co-theme Leader, Maternal Child Health in the School of Population and Public Health at UBC and Associate Faculty in the Departments of Family Practice, Midwifery and Obstetrics and Gynecology. She teaches a graduate course in perinatal epidemiology. She undertakes clinical trials to evaluate aspects of clinical care during the perinatal period and utilizes population data in BC to evaluate outcomes and costs associated with models of maternity care.
Learning Objectives

1. Identify preterm birth, very low birth weight, NICU admission for one to three days, and mean birth weight, as outcomes shown to be positively associated with midwifery care for women of low SEP;

2. Identify low-income African American and low-income nulliparous women as populations found to benefit from midwifery care;

3. Explain the need for more studies, and of greater quality, in order to conclusively determine the influence of midwifery care on birth outcomes for women of low SEP.
Evaluation of the SOGC Guidelines for Fetal Surveillance in Labour: A Pilot Study

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Abstract

Rates of caesarean sections ("cs") in Canada are questionably high, approaching 1/3 of all deliveries in several provinces. One reason to perform cs is fetal distress, which is a difficult diagnostic since interpretation of continuous fetal monitoring has limited intra-observer and inter-observer reliability. In many cases where cs are performed for fetal distress, babies are born completely healthy. To address the issue, the Society of Obstetricians and Gynecologists of Canada published a clinical guideline on fetal monitoring in 2007 in order to promote cautious use of continuous fetal monitoring. More than seven years later, fetal distress remains one of the most frequent reasons for cs and continuous fetal monitoring remains the preferred method used to evaluate fetal well-being during labour. Our overall purpose is to determine if SOGC Guidelines are being followed with respect to diagnosis of fetal distress during labour and if recommended management is undertaken in response to the diagnosis. We reviewed 600 medical charts that had been identified with fetal distress during labour (ICD-10 code 068) in four hospitals of British Columbia. The primary outcome is caesarean section and the secondary outcomes include neonatal outcomes, such as Apgar scores, arterial blood gas and requirement for oxygen for more than 24 hours. The data are being analyzed now. Results will be ready during the fall. As this was a pilot study, we recognize our limitations and we would like to share our ideas on how future studies should be conducted to further develop the answer to this question.

Biographies

Karine Vallée-Pouliot is a midwife who has been working at the Maison de Naissance Côte-des-Neiges since June 2009. After obtaining a Bachelor degree in Human Physiology as well as a Minor in Pharmacology at McGill University in 2005, she completed her Bachelor degree in Midwifery at Université du Québec à Trois-Rivières in 2009. She recently completed a Master of Science in Public Health in the Department of Epidemiology, Biostatistics and Occupational Health at McGill University.

Learning Objectives

1. Identify the important components that are needed to make the timely diagnosis of fetal distress and its appropriate management
2. Recognize the difficulties associated with conducting a study on fetal surveillance during labour
Keeping the Baby in Mind: Integrating Mentalizing With the NBO System

Joanne Crandall

Author
Joanne Crandall
Registered Psychologist
MCFD

Abstract
Giving birth marks the beginning of relationship development between the baby and the parent. Developing relationship includes making meaning of the baby’s behaviours. Two systems of meaning making when working with parents and the baby are the New Born Observation System (NBO) and mentalizing. The NBO (New Born Observation System) is a relationship-based intervention that helps parents to understand what the baby is capable of doing during the first three months of life. It helps parents to appreciate the uniqueness of the newborn and how to best respond to the baby’s needs. Mentalizing seeks to keep both self and other in mind when making sense of the thoughts and feelings that lie behind behaviour. Integrating mentalizing and the NBO facilitates a deeper connection between parents and the baby.

This workshop will explore how to integrate the NBO system and mentalizing. Through videos, participants will learn how the NBO is conducted. The participants will also learn about the components of mentalizing and how using mentalizing with the NBO will help parents to become more open and curious about what they are experiencing and how they can make meaning of their relationship with the baby. Finally, participants will be able to discuss the implications for practice when working with newborns and their families and have new insights and strategies on how to best work with parents of newborns that promote the notion of keeping the baby in mind.

Biographies
Dr. Joanne Crandall is a Registered Psychologist who works for the Ministry of Children and Family Development in Northern BC. Joanne has made Infant Mental Health her primary clinical focus for the past decade and is a certified NBO (New Born Observation system) facilitator. She is an engaging and dynamic presenter.

Learning Objectives
1. Learn how to integrate the NBO system and mentalizing
2. Through videos, participants will see how the integration of the NBO and mentalizing promotes meaning making for the parents
3. Gain new insights and strategies on how to best work with parents of newborns that enhance the notion of keeping the baby in mind