



**Perinatal Services BC**

An agency of the Provincial Health Services Authority

# PROGRAM MANUAL

## **STARTING A COMMUNITY BIRTH PROGRAM**

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# 1. BACKGROUND

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The future of maternity care in Canada has become a topic of some concern in recent years. The last two decades has seen a dramatic decline in the number of family physicians (FPs) providing maternity care. Reasons for this decline have included lifestyle issues, perceived competence, and liability concerns. As well, a large number of obstetricians and FPs who do provide maternity care will reach retirement age within the next decade. While regulated midwifery care has been growing, the proportion of births attended by midwives still remains small. As a result, lack of access to maternity care has been linked with hospital closures in rural settings and has made it increasingly difficult for women to access obstetric care, particularly in rural settings.

The provision of maternity care is complicated by a dramatic increase in rates of interventions during childbirth; cesarean section rates have risen from 17% in the 1990s, to 28% in 2009. This increase has occurred despite a lack of evidence that maternal and newborn outcomes have improved. In addition, an increase in cultural and linguistic diversity has made the delivery of maternity care more challenging. In British Columbia, 16% of the population speaks neither official language at home. There is evidence that immigrant women are at increased risk of obstetric interventions and less likely to breastfeed.

It was in response to these issues that the South Community Birth Program (SCBP) was established. The goal was to provide comprehensive, collaborative maternity care with a team of family physicians, midwives, nurses and doulas, to the multiethnic, low-income population in South Vancouver. The program aimed to promote physiologic birth while encouraging women to assume an active role in their maternity care. At the time of SCBP's launch, there were very few physicians or midwives providing full-scope maternity care in this low-income area of the city.

Since launching in 2004, the SCBP has grown dramatically and in 2013, it will provide primary maternity care for 450 – 500 women. Feedback on the program from women and their families has been very positive. The majority of new client referrals are through word-of-mouth from past clients or friends/families of past clients.

While receiving care in a group setting is very different than standard individual care, women at SCBP rate their satisfaction with Connecting Pregnancy (CP) group care very high. Many women (and their partners) report that the friendships made during their

CP groups become lasting connections and often become important supports during challenging moments as they adjust to new parenthood – long after the group ends.

In 2012, a retrospective cohort study was published in the *CMAJ*, *Effect of a collaborative Interdisciplinary maternity care program on perinatal outcomes*. From April 2004 to October 2010, the outcomes of 1238 births at SCBP were matched to a control group of women receiving standard care from obstetricians, midwives and family physicians at BC Women’s Hospital. The study found that women receiving care at SCBP, were “less likely to have a cesarean delivery, had shorter hospital stays on average and were more likely to breast-feed exclusively than women receiving standard care.”<sup>1</sup>

In light of the experience of the SCBP, interest has grown in community birth programs (CBPs) as a collaborative multi-disciplinary model of maternity care. This manual aims to provide an overview of the CBP model, and describe the processes involved in creating a successful and effective CBP.

## 2. WHAT IS A COMMUNITY BIRTH PROGRAM?

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Community birth programs (CBPs) provide comprehensive prenatal, labour and birth, and postpartum care to pregnant women. The goal of the CBP is to bring birth back to a community-based, culturally-appropriate, primary care experience. The care offered in a CBP differs from standard maternity care in a number of important ways:

- **Collaborative practice:** midwives, physicians, nurses/lactation consultants and doulas are integral members of the care team.
- **Collaborative primary care:** midwives and family physicians share the primary care of patients. Nurse practitioners may also be involved in primary care.
- **Doula care:** women are offered the support of a doula, matched for language and “character fit”.
- **Group care:** women have the option of receiving their prenatal and postpartum care in a group setting where they also receive their medical care, rather than standard one-on-one appointments.

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<sup>1</sup> Harris et al. “Effect of a collaborative interdisciplinary maternity care program on perinatal outcomes.” *CMAJ* November 20, 2012, 184:1885-1892.

- **Woman/Family-Centered Care:** assists women and their families to identify their own strengths and build confidence in their ability to give birth and become parents, while assuming an active role in their own health care.
- **Support of physiologic birth:** strives to provide a safe and positive birth experience through the reduction of interventions.

## 2.1 COLLABORATIVE PRACTICE

In the CBP shared care model, women benefit from the different expertise and professional support that occurs between midwives and family physicians. The CBP shared care model embraces working principles that are based on mutual respect, trust, teamwork, and aims to promote physiologic birth, patient education and patient empowerment.

The primary care team develops protocols and guidelines that support normal birth with regular opportunities for evaluation and improvement. Regular communication and team meetings promote a collaborative approach to care planning, particularly with complex care patients. The goal is to have all members of the team “on the same page”, so that transfer of care in labour from one primary care provider to another is seamless.

Features of collaborative models have been described by the Multidisciplinary Collaborative Primary Maternity Care Project (MCP<sup>2</sup>)<sup>2</sup> as outlined below:

- **Woman-Centered:** Women are the center of the care, in both the Connecting Pregnancy groups and also in individual care. Effort is made to address their care and educational needs as they identify them
- **Quality Maternity Care:** Care providers constantly review and discuss case management and address issues of care in a continuous, quality improvement process; e.g. postpartum follow-up has been determined by the experiences of women in the program
- **Best Evidence and Practice Guidelines:** Team members review current literature and guidelines at regular retreats and team meetings
- **Professional Competence:** Team members are chosen for their experience and competence
- **Commitment to the Collaborative Model:** All team members are committed to the idea of working together as a team to provide better care. All of the providers

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<sup>2</sup> <http://www.mcp2.ca/>

regularly attend meetings and retreats in order to facilitate their role as a team member

- **Mutual Trust and Respect:** Team members learn from each other and value the input from others about practice issues
- **Shared Values, Goals and Visions:** Team members have spent considerable time developing a vision and philosophy that emphasizes woman-centered care
- **Honest, Open, and Continuous Communication:** Communication occurs daily and there is openness about any concerns. In addition, discussions about cases and issues of concern take place at monthly team meetings
- **Responsibility and Accountability:** Team members are accountable for the care that they provide and any actions which affect other team members
- **Scope of Practice:** Adjustments and compromises are made to accommodate the different scopes of practice and philosophy of care of the midwives and family physicians
- **Common Protocols:** Protocols have been developed and adapted, to reflect new evidence and women-centered care
- **Mutually Supportive Environment:** Team members all work together to support one another, both personally and professionally
- **Acceptance to Discuss Financial Issues:** Financial issues are openly discussed and planned by the team. The midwives and physicians have adopted an equitable pay model; all monies earned are pooled and divided equally for prenatal, postpartum and group care, as well as on-call shifts. This greatly facilitates the reduction of barriers between the professions
- **Locally-based:** CBP's are located in the community and emphasizes continued care in the community and return to home as soon as possible after the birth
- **Effective, Integrated Regional Provision of Services:** Women are integrated back into their community when discharged from the CBP. They are also returned to their general physician with a summary of the pregnancy and birth and any relevant information
- **Knowledge of Available Services:** The CBP works directly with the community and utilizes services that are close to home for the patients.

## 2.2 CONNECTING PREGNANCY GROUP CARE

The group prenatal care system known as Connecting Pregnancy (CP) is a relatively new model of maternity care delivery in B.C. Connecting Pregnancy has been adapted from a model that originated in the U.S. called *Centering Pregnancy*, which began in the mid-

'90s. Many different healthcare centres now offer programs based on group care, and these programs share similar values of collaborative multidisciplinary teamwork.

CP alters routine prenatal care by bringing women out of exam rooms and into groups for their care. At the CBP, women have the option of receiving their care in a group setting, which incorporates medical assessment, education, and support.

Initially at SCBP, it was difficult to convince women of the benefits of group prenatal care. Uptake of the CP groups was slow to build with 39% of women participating in the first year. Once a few groups were established, word-of-mouth spread among women and this ratio of participation in CP groups reversed. By year three, 66% of women received their prenatal care in CP groups and today, 85% of primiparous women participate in CP groups and there are wait lists for participation. However, there remains a number of women who choose not to participate and a number of women who cannot arrange their schedules to participate in group care. These women continue to receive prenatal care in the standard way, with one-on-one visits in the office, with either a midwife or physician. It is the feeling of the providers that women and their partners attending CP groups are better prepared for the birth and the arrival of the baby.

#### HOW CONNECTING PREGNANCY WORKS

The groups are co-facilitated by a primary care provider (midwife or family physician) and a nurse. The primary care provider and nurse remain with the same group from start to finish (team members may fill in for holidays or sickness). For three of the ten sessions, the co-ordinator of the doula program co-facilitates the groups to educate women about the doula program and doula care. The nurse does not attend these sessions.

Women have their initial intake, history, and physical exam done at individual one-on-one appointments with a midwife or physician. They are then invited to join with 8-12 other women (or couples) with similar due dates (ideally the same “due month”) to meet regularly over the course of their pregnancy, beginning at around 18 or 20 weeks GA. There are ten sessions in total, with the first 4 occurring every 4 weeks, and then the next 6 sessions every 2 weeks. The last session of each CP is timed to occur when all women in the group would be 41 or 42 weeks GA, to ensure at least one final group meeting occurs after all members have delivered. (Of note, women without risk factors who choose “individual care” instead of CP groups are still seen every 2 weeks after 32 weeks for their care. Once the gestation is 39 weeks, all women are seen on a weekly basis.)



## THE THREE COMPONENTS OF CP

### Assessment

Women enter a CP group after their initial prenatal intake visits/evaluation is completed. The standard prenatal assessment (baby's heartbeat, growth and position) is completed within the group setting with a "three-minute belly check". Women participate actively by checking their own weight, blood pressure, and urine and record these findings on a piece of paper that are then entered into their charts. The women (and their babies) are seen in the group by the physician or midwife. Specific problems may be addressed at the belly check but general questions are directed back to the group. Together with other CP group members they share in discussing topics of interest related to pregnancy, childbirth, parenting, and family dynamics. If more time is needed to address individual concerns, a one-on-one appointment is booked for follow-up in the clinic. Primiparous women highly value the participation and input of the multiparous or experienced mothers in their group, who give advice based on their own experiences.

### Education

A general curriculum is outlined in the CP Handbook, a binder (or electronic format) which each woman receives at the first group. Topic areas are set for each session but may be altered to focus on specific needs identified by the women/couples. The education process occurs through a group discussion format and includes; exercise/relaxation, nutrition, pregnancy problems, pregnancy and birth comfort measures, childbirth preparation, infant care and breastfeeding, postpartum issues, communication and self-esteem, sexuality, violence and abuse, relationship issues and general parenting.

### Support

Given the sensitive nature of some of the topics, groups are closed to new members after the third session, which allows for the building of trust among the group and co-facilitators. Students (midwifery, medical and nursing) must commit to the CP groups for the full duration and cannot come and go. Outside observers are not permitted. Women and couples become invested in each other and build community as a result of their interactions. This leads to increased support and decreased feelings of isolation. Time for refreshments and socialization during the sessions helps to promote cohesion. When the CP group has ended a reunion is scheduled for one month later,

often at one of the group participant's home. The entire group or individual members of a group can continue to meet, sometimes for several years after.

## 2.3 DOULA PROGRAM

The word Doula refers to a supportive companion (not a friend or loved one) experienced in attending childbirth and trained to provide continuous emotional and physical support during labour. Evidence suggests that doula support can have enormous benefits for the mother, newborn, and family. There have been several randomized trials confirming the benefits of the presence of a doula. The initial studies confirmed doula support reduces the overall cesarean rate by 50 percent, the need for forceps by 40 percent, the length of labor by 25 percent, oxytocin use by 40 percent, pain-medication use by 30 percent and requests for epidurals by 60 percent. Women randomized to receive doula support also report higher self-esteem and stronger feelings of attachment to their newborn six weeks after birth than women who did not receive doula support.<sup>3</sup> A recent study in the American Journal of Public Health (2013) found that doula support in labour was associated with a 40% decrease in cesarean deliveries among Medicaid recipients; they found a cesarean rate of 22.3% with doula care compared to 31.5% among other Medicaid recipients.<sup>4</sup> In addition, a recent Cochrane review showed care by a doula resulted higher levels of vaginal birth and lower odds of cesarean delivery, as well as fewer epidurals and less frequent instrument-assisted delivery. The Cochrane review also found a correspondence between labor support and shorter labors, as well as higher levels of satisfaction among women receiving such support.<sup>5</sup>

Doulas are an integral part of a CBP and an enormous part of the program's success. Women are informed about the doula program at their first prenatal visit and learn more about doula care in CP group sessions.

Doulas are assigned to women after being matched by the Doula Coordinator for age,

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3 Sosa R, Kennell JH, Klaus MH, Robertson S, Urrutia J. "The effect of a supportive companion on perinatal problems, length of labor, and mother-infant interaction," *N Engl J Med*, 303:597-600, 1980.  
Klaus MH, Kennell JH, Robertson SS, Sosa R. "Effects of social support during parturition on maternal and infant morbidity," *Br Med J*, 293:585-587, 1986.  
Kennell JH, Klaus MH, McGrath SK, Robertson S, Hinkley C. "Continuous emotional support during labor in a US hospital: a randomized controlled trial," *JAMA*, 265:2197- 2201, 1991.  
Kennell JH, McGrath SK "Labor support by a doula for middle-income couples; the effect on cesarean rates," *Pediatric Res*, 32:12A, 1993.  
McGrath SK, Kennell JH, "Induction of labor and doula support," *Pediatric Res*, 43(4):Part II, 14A, 1998.

4 Katy Backes Kozhimannil, Rachel R. Hardeman, Laura B. Attanasio, Cori Blauer-Peterson, and Michelle O'Brien. Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries. *American Journal of Public Health: April 2013, Vol. 103, No. 4, pp. e113-e121.*

5 Hodnett E, Gates S, Hofmeyr G, Sakala C. Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews* 2003. Issue 3, Art. No. CD003766. DOI: 10.1002/14651858.CD003766.

geographic area, first language, and cultural background or religion. The doulas, where possible, speak the woman's first language (as well as English). Very infrequently, women ask to meet another doula after the first contact; this matching system works very well.

The doula contacts their assigned client as soon as she receives her contact information, usually between 35 – 37 weeks. Initial contact is almost always by telephone. The doula will arrange a prenatal visit at a mutually agreed upon location and time, usually the woman's home. The purpose of the prenatal visit is to become acquainted and comfortable, while gathering information about the women and partners plans and desires for the birth. Not all women are interested in birth planning. The doula will explain her role of support during the process. The visit also allows the doula to become familiar with the location of the clients home, etc. During the visit the doula should acknowledge that she has signed a pledge of confidentiality. During the initial visit the doula will ensure the woman understands when to call her (even if it is in the middle of the night) and she is also informed to also contact the care provider on-call at the onset of labour.

As per the Doula Standard of Practice the doula does not perform clinical tasks or offer medical advice. If clinical questions arise during the prenatal visit, the doula advises her client to bring the question to the care provider at the next clinic or group visit. It is crucial the doula remembers that the effectiveness of doula care is rooted in the continuous physical and emotional support, and "mothering the mother", while including her other support people.

Doulas will meet with the woman and her partner three times; one home visit before the birth, continuous presence throughout the labour and birth, and one home visit after discharge from the hospital. Doulas try and schedule their postpartum visit within the first week after the birth. They are also available by email, phone and text throughout the course of care.

The doula provides early labour support in the woman's home (if appropriate), accompanies her to the hospital and remains with her throughout the labour and birth and a few hours postpartum.

Doulas are supplied with a "bag of tricks" when they join a CBP, which includes a TENS machine and pads, Rebozo and labour links (for 2<sup>nd</sup> stage pushing). During labour:

- The doula provides continuous assistance and comfort to the women and other support people to enhance the birth experience and create and maintain a supportive emotional environment
- The doula assists women with breathing, relaxation and position changes during the course of labour
- The doula enables the family to assume an active role whenever possible by modeling supportive behaviors and encourages partners to participate at their own comfort level
- The doula helps to ensure the woman maintains adequate hydration during labour
- The doula may provide massage techniques as part of her supportive role
- The doula encourages the woman to ambulate.
- If a woman requires a caesarean section, every attempt will be made for the doula to be present in the Operating Room (discretion of the Anesthetist).

If the primary doula is with another woman in labour or unavailable for personal reasons she must call a back-up doula to go and support the women and her partner. The doula will have a back-up doula in place if she is going to be unavailable for a period of time. The women will be provided with the contact information of the backup.

The doula documents each birth in the Doula Attendance Log, which is sent each month to the Doula Coordinator. Finally and most importantly, the doula provides continuity of care for each woman she attends, remaining by her side throughout her labour and birth.

#### THE DOULA COORDINATOR

The doula coordinator is an experienced doula who recruits, trains, and matches the doulas with women receiving care. She also co-facilitates three CP group sessions, providing information about the doula program and doula care in general. The responsibilities of the doula coordinator include:

- Recruiting and managing all of the doulas who work within the program
- Assigning doulas to all patients requesting a doula, taking into consideration specific patient needs and preferences
- Liaising with patients about issues related to the doula program
- Liaising with care providers about issues related to the doula program
- Managing all invoicing related to the doula program
- Tracking on the Doula Attendance log and the Birth Roster

- Filing an Annual Report on the Doula Program

The Doula coordinator is also responsible for tracking all of the births attended by doulas. The Doula Preference form and the Doula Attendance Log are included in an attachment to this document called “CBP Templates”.

#### RECRUITING & TRAINING DOULAS

The doula coordinator recruits doulas by distributing flyers to local community centres, public health units, temples, churches, and community groups in the vicinity. The coordinator may also hold public information nights. Interested women are interviewed and then enrolled in a DONA (Doulas of North America) Approved Training. All new doulas in the program attend a training program paid for by the CBP. Doulas in the community that have already attended a DONA training are also recruited but in order to ensure diversity and increase the possibility of being able to offer doula support in many languages it is often necessary to recruit and train new doulas.

#### DOULA MENTOR PROGRAM

The CBP Mentor Doulas are experienced doulas who clearly understand the role of the doula and the concept of collaboration. These doulas must have attended a minimum of 50 births or have been on the CBP team for 3 years.

Women are asked if they would be amenable to having a mentor and trainee doula at their birth. The large majority respond positively to having two doulas attend them in labour.

Mentor or “shadow” births are arranged by the doula coordinator and are considered part of the new doulas training, as well as an orientation to the hospital. The doulas receive training, guidance and support from the experienced mentor doulas and have found the experience invaluable. The mentor receives the doula honorarium while the trainee does not receive an honorarium.

Doulas attend a minimum of three births with an experienced mentor, more if needed. She is assigned a client and is observed by the mentor doula. There is a final evaluation which includes feedback from both the mentor doula and the physician or midwife attending the birth. The new doula also has the opportunity to evaluate herself and her experiences. The doula coordinator discusses the evaluation with each doula before she no longer attends births without a mentor.

New doulas are given a “CBP-Doula” name badge to wear while attending births with a mentor. If at the end of the evaluation period the mentor, doula coordinator and the

care providers feel the new doula is a positive addition to the team, she is invited to get her photographed hospital CBP-Doula ID badge.

New team additions also have a current criminal record check completed and have signed the CBP Standard of Practice and Confidentiality agreements.

#### FUNDING/PAYMENT

The SCBP doula program has been generously supported by the Provincial Health Services Authority, BC Women's hospital. However, this funding is provided with the understanding that it will represent a cost saving by reducing the length of hospital stay. This is one of the reasons CBPs should have an early discharge program. A second benefit and cost saving linked to a doula program is in translation services, as the doulas are often able to provide language support during labour. Women appreciate first language support in labour, even if they speak some English.

Doulas are categorized as volunteers and are paid an honourarium for their care. At SCBP, the doula team is a diverse group ranging in age from mid 20s to early 50s. Many work part-time outside of their work as a doula and a small number have full-time jobs that allow some flexibility. Almost half, 42% of the doulas work only as a doula and while some take private clients as well as their SCBP clients, 32% only attend births as an SCBP Doula. The number of clients an SCBP doula cares for in a month is at her discretion; it ranges from 50 to 5 births a year. The doulas let the doula coordinator know their availability each month. Because they are only paid an honourarium and work at other jobs, the doulas work in partnership in case they have to leave a birth to go to work. Patients are informed that this is a possibility when they request a doula.

SCBP doulas are paid an honorarium of \$250 a course of care which includes one prenatal visit, attendance at the labour and birth and one visit after the baby is born. Doulas that have been with the SCBP for a minimum of 3 consecutive years and attended a minimum of 50 births receive an honorarium of \$350. Many of the doulas maintain texting and phone contact with their clients after the first meeting, particularly if they are new to the country or high-social risk.

#### LANGUAGES AND TRANSLATION

As of March 31, 2012, forty doulas at SCBP spoke the following languages as well as English: Indonesian, Spanish, German, Mandarin, Cantonese, Czech, Slovak, Russian, Tagalog, Cebuano, Hindi, Punjabi, Urdu, Portuguese, Nepali, Japanese, French, Gujarati, Italian, Farsi and America Sign Language.

SCBP Doulas translated 103 times for their clients at clinic appointments in 2012. The most common languages translated at prenatal visits are Japanese, Hindi and Punjabi. Doulas are paid \$30 per clinic appointment. Translations are arranged with the doula by the SCBP office staff when client appointments are booked.

### DOULA TEAM MEETINGS

There are two all-day doula team meetings per year. One is usually an exchange of “hands-on skills”. Doulas were asked to bring their favourite skill to the workshop, such as using the Rebozo and Labour Links. New doula team members are introduced and a few nurses, physicians or midwives attend for an open dialogue about the dynamics of working together as a team, hospital policies and doula attendance in operating room. The second team meeting is a workshop with a guest teacher (such as Penny Simpkin).

In December, there is an annual “Celebrating the Doulas” event, a large international cuisine pot-luck where all the team members (physicians, midwives, nurses, clerical staff) host the doulas and their families at the Directors home, in order to appreciate the doulas contribution to the team. This event is very well attended and important for team building.

## 3. GETTING STARTED

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### 3.1 ELIGIBILITY

Clients are either referred by their family physician who does not do obstetrics, a family member, or often, through word-of-mouth from a past patient of the program. Women do not need a referral to join the program and are encouraged to self-refer. All the program's services, including CP groups and doula care are free of charge. High-risk pregnancies are referred to an obstetrician for care/delivery. This decision is made in discussion with midwife/physician providers and at times the woman, to ensure the program is as inclusive to as many women as possible. For example it may be possible for women to participate in a group and have shared care with an obstetrician if appropriate.

CBPs are generally open to all women living in the designated catchment area of the program, although priority may be given to underserved women (including new immigrants, low-income families, pregnant teens, women with substance dependency issues, or other marginalized women).

## 3.2 PROGRAM PROMOTION

### INFORMATION FOR WOMEN AND THEIR FAMILIES

Once CBPs have become established, patients will likely be referred by a core group of physicians and through word-of-mouth. Before this point, however, advertising is likely necessary to promote the program to women. Mail-outs with information about the CBP should be done to all GPs in the area who do not provide obstetric care. Other forms of advertising, such as print, billboard, transit, etc, may also prove beneficial.

A website has proven to be highly beneficial, as is a social media presence. Having a website also has the advantage of being able to distribute resources and information directly to women before they attend the clinic and throughout their care. Websites and social media accounts can be used to share information about the program, introduce team members, highlight program features such as CP and doulas, share links to high-quality resources and information, and create a space where families attending CP groups can stay in touch.

### INFORMATION FOR REFERRING GPs

Promotional information can also be shared with other care provider clinics, especially with GPs who do not provide maternity care. Other family practice and midwifery clinics may be interested in having referral information in case their practices are full, or they have clients who they feel may benefit from the structure of care in a multi-disciplinary program.

Referral forms for the CBP can be made available on the CBP's website. Once a client is referred and seen, a thank-you letter is generated and sent back to the referring GP. A discharge letter is also sent to the referring GP upon completion of a client's care, including a summary of the delivery. See Referral Form template in the Appendix.

## 3.3 COLLEGE REQUIREMENTS & RESTRICTIONS

In the past, the College of Physicians and Surgeons of BC prohibited family physicians from attending homebirths, which effectively prevented collaborative practices from offering home births. The CPSBC rescinded the ban, making it possible for CBPs to offer choice of birth place. However, as most family physicians lack training in home birth management, there is currently a home birth training program for physicians underway.



The CBPs in BC are in ongoing negotiation with the College of Midwives of BC (CMBC), in order to find ways in which the registration requirements for midwives can be met in a multi-disciplinary practice.

### 3.4 ELECTRONIC MEDICAL RECORDS

Electronic medical record (EMR) systems are essential in effectively managing team-based shared care. EMR systems allow all patient information, records, forms, labs and charting to be available to all team members simultaneously, in real time as information is entered. The Open Source Clinical Application Resource (OSCAR), is an inexpensive, open-source EMR program, and is being used by both the SCBP and the Surrey CBP.

OSCAR was developed in Ontario by a family physician, Dr. David Chan, at McMaster University. Advantages of OSCAR included free software without royalties or licensing fees, no vendor lock-in, free source code that can be modified to suit individual clinic. In B.C., there is a nucleus of midwives and physicians very active in the OSCAR community. SCBP signed on in early 2004 and has continued to update the provincial PSBC maternity care forms. These forms are available for downloading, at no cost.

Although OSCAR is freely available as open-source software online, technical support is usually necessary for the system set-up. There are several OSCAR support businesses in BC, who provide daily support services and secondary servers to securely store records. For the less technically capable, professional support is invaluable in order to ensure reliable data security and backup.

### 3.5 MEDICAL OFFICE ADMINISTRATOR (MOA)

The office administrator (MOA) is the first point of contact for the CBP. The MOA's tasks include:

- Answering client inquiries about the program, taking referrals and enrolling new clients
- Booking appointments; calling the day before to confirm
- Scheduling ultrasounds, amniocentesis, specialist consults; tracking down and ordering client results
- Orientates women re self-care: taking and recording her BP, urine and her weight

- Importing electronic and faxed labs into the EMR system
- Keeping track of new patients sign-up on the CBP Birth Roster
- Tracking CP group sign-up and ongoing membership
- Scheduling and alerting patients to “Meet the Team” nights
- Updating clinic and on-call schedules
- Responsible for overhead bill payment (not payroll)
- Responsible for provider MSP billings
- Maintaining pre-registration records

The MOA plays an important role in ensuring that all information is readily available and flowing smoothly between all team members.

### 3.6 EVALUATION

Evaluating patient satisfaction with the program is important both to identify opportunities for improvement and hopefully to hear what you are doing right!

The CMBC requires that all midwifery practices survey their patients for feedback and to measure their satisfaction with care.

The SCBP has developed a detailed survey that asks questions about all aspects of care, including satisfaction with group care. It can be administered simply (and at low cost) over email through [surveymonkey.com](https://www.surveymonkey.com), or as a paper survey distributed in the office to women prior to their discharge from care. It can be adapted for any CBP’s use.

An example of a survey questionnaire developed and used by the SCBP is included as an attachment to this document.

## 4. COLLABORATIVE TEAM WORK

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As a participative, team-oriented program, the CBP’s management structure encourages a broad base of input from its care providers and the community at large, along with ensuring clear lines of responsibility and accountability for financial and quality assurance matters. The administration and team structure of the program breaks down as follows.

## 4.1 THE PRIMARY CARE TEAM – PHYSICIANS AND MIDWIVES

Women enrolled in the CBP receive primary care from registered midwives and family physicians. Care is shared in such a way that women in the program could be attended at their labour and birth by any member of the midwifery/family physician team.

### ANTENATAL CARE

Antenatal care is coordinated by an identified lead provider, either her CP group leader or an assigned leader for single visit, individual care. When necessary, women are referred to an Obstetrician for a consultation or transfer of care. The CBP providers function as a team, collaborating with CHNs, nurses, doulas, dieticians, physiotherapists, social workers, mental health professionals and translators, when necessary. Discussions about clients and care issues take place on a daily basis through the electronic medical record (OSCAR), and in more detail on a monthly basis at team meetings.

### INTRAPARTUM CARE:

When a woman goes into labour, she pages the midwife or physician on-call, as well as her assigned doula. Before labour becomes active, the doula is often in attendance in a supportive role at the woman's home. She is in contact with the on-call provider, updating on the progress of labour. Occasionally, the provider first attends the woman in her home during labour, assessing cervical dilation, fetal heart, blood pressure and labour progress. All of the providers carry the equipment necessary to assess maternal and fetal well-being out-of-hospital. Admission to hospital is postponed until the labour is active, which is often around four to five centimeters dilated. The provider admits the patient to hospital and stays in hospital until the birth is completed. The on-call midwife or physician may leave the hospital to do a postpartum home visit but they are available at all times for labour assessments and do not run clinics or groups at the same time.

Although their scope of practice is similar, midwives are required to consult an obstetrician (e.g, for vacuum extraction) or for induction of labour. Consultation protocols vary from one hospital to the next. When either a midwife or family physician is on-call and attending the labour, they continue to consult as per protocol at each hospital.

### POSTPARTUM CARE

Following a normal birth, early discharge from hospital is encouraged and supported. If the woman and her baby are discharged from the hospital in under 24 hours following the birth, the provider on-call will see her at home the next day and do the PKU. This plan is very well received by women and early discharge rates increase if women are

assured they will be assessed in a timely fashion. On occasion when circumstances warrant it, home visits may also be done on day 2 and/or 3 (example; weekend with no office, newborn weight loss requiring follow up, mental health issues, transportation issues, etc). Follow-up postpartum visits take place in the clinic and breast feeding support / lactation consultation is provided by the RN team. The Midwife or physician is available to see the patient if there are medical problems.

The patient has the choice of booking her final discharge postpartum visit with either her lead midwife or physician or the primary care provider that attended her birth. This visit is booked between 6 to 12 weeks. Additional visits may be booked prior to the discharge visit at the woman's request, as she may want to debrief her birth experience sooner. Every effort is made to find the woman a general physician if she does not have one.

## **4.2 THE NURSING TEAM**

Nurses (RN), Lactation Consultants (LC) or Nurse Practitioners (NP) are an integral part of the team. The primary role of the RN/LC is focused on postpartum care, particularly breastfeeding education and support. Postpartum clinics are run with 45 minute scheduled appointments and as drop-in clinics.

The RN/NP also co-facilitates seven of the ten CP group sessions. This is particularly useful in the later groups when both the mother and baby are attending.

## **4.3 DOULA COORDINATOR**

The Doula Coordinator recruits, trains and supports the program's doulas. The Coordinator attends team meetings and retreats and is involved in the care planning of patients. This allows her to plan appropriate doula support according to women's needs.

The Doula Coordinator also co-facilitates three of the ten CP group sessions, providing information on doula support and the CBP's doula program.

## **4.4 CBP DIRECTOR**

A CBP Director or Team Leader is necessary to lead the team, ensuring appropriate communication occurs, an atmosphere of equality and mutual respect is built, protocols are developed and renewed, and quality assurance measures are in place. The Director also has the responsibility of administering the program, eg, hiring staff, scheduling,

financial planning, and other duties. The team leader is ideally a midwife or physician, or a shared position by both.

#### 4.5 MEET THE TEAM EVENT

The “Meet the Team” (MTT) event is an opportunity for women to meet all the team members who may be involved in their birth and postpartum care. Women receive an invitation by email and/or handout at their CP/clinic visit 2-3 months prior to their EDD to attend. The MTT is held on a weekday evening, Monday to Thursday, from 5:30 to 7:00pm, which allows working women and their partners to attend. Physicians, midwives (plus locums) and nurses all attend. This is a paid and required event for care providers to attend. Frequently, a few doulas also attend.

The MTT event is an informal gathering and panel discussion. CBP team members introduce themselves and patients have an opportunity to ask questions and speak with individuals informally.

The MTT also assists midwives in meeting the CMBC’s continuity of care requirement, ensuring that clients have had an opportunity to meet all of the care providers who may attend them during labour and birth.

#### 4.6 CALL, CLINIC AND CP SCHEDULING

All midwives and family physicians, whether full-time or part-time, cover a minimum number of day, night, and weekend call shifts each month. They also run sessional clinics and CP groups (3.5 hours), which occur both during the day and weekday evenings.

##### CALL SCHEDULES

The length of call shifts is dictated by the volume of patients in the practice. In low volume settings, 24 hour shifts are often appropriate. In high volume settings, call shifts may not exceed 12 hours. At SCBP, call shifts run for 10 hour days (8am to 6pm) and 14 hour nights (6pm to 8am).

An example of a monthly call schedule is included in an attachment to this document called “CBP Templates”.

##### SECOND ON-CALL

Second on-call is covered on a rotating basis throughout the team of midwives and physicians. In a high volume practice it can be difficult to leave the hospital to do home

visits. Also, locum coverage, particularly newer graduates or care providers who have not worked in the CBP or hospital often need more mentorship. The second on-call is paid a flat rate to be available and also paid for any call out, including home and hospital visits.

- Finding a locum replacement in an emergency to cover the on-call provider's 12 hour shift (illness, family emergency, etc)
- If unable to find a replacement, providing on-call coverage in an emergency until a locum can be found
- Doing home, hospital or assessment room visits when the on-call provider is too busy at the hospital or cannot leave a birth
- Providing telephone support to the on call provider if she should need some advice re: a case or difficult situation
- Covering the pager calls for the on call provider if she is too busy to answer
- Entering the INBOX labs in OSCAR for the on call provider when she is busy
- Providing in hospital support for the on call provider in the event of a bad outcome requiring clinical or emotional support (extra pay)
- In house presence to mentor providers, particularly new members of the team, with a difficult case or with suturing (extra pay)
- Prepping appointment screen for next day if on-call too busy
- Helping with charting (starting summary forms, etc) if on-call too busy
- Ensuring that all charting is complete each day, including the d/c time in L&B.

## CLINIC SCHEDULES

Throughout the week, both prenatal and postpartum clinics are scheduled; women are seen by a physician or midwife for their first 2-3 visits before joining a CP group. Women receiving one-on-one care are also seen in the clinic. There are two clinics a week held on the same night in the evening – from 5:00 to 8:30pm. Clinics are paid at a sessional (3.5 hour) rate; CP groups run for two hours and are also paid at a sessional rate of 3.5 hours.

In order to keep clinical schedules consistent, the calendar year is divided into recurring 4-week sets (Week 1, Week 2, Week 3, Week 4). A rotating schedule is instituted and repeated throughout the year. This 4-week schedule is important to the smooth running of CP scheduling (below).

An example of a monthly clinic schedule is included in an attachment to this document called “CBP Templates”.

### CP GROUP SCHEDULES

Facilitation (leadership) is key to CP group care success. Women, care providers, and labour and delivery nurses all report a distinct difference in birth preparation between traditional prenatal classes and women prepared through group care. In contrast to prenatal class didactic teaching, the group facilitator strives to build an open, supportive and interactive community within the group.

It is important that women understand that when they join CP group care, it encompasses their medical care check-up as well. They are informed that they cannot do both CP group care and one-on-one care. If they miss two or more CP groups, without notice, they are encouraged to discontinue CP group care and book individual appointments. At times, women know in advance they will be away and unable to attend specific groups and will make individual appointments to accommodate their schedule. However, women must be made aware that this is not an optional prenatal class; in addition to receiving their medical care, a supportive, cohesive group identity, only built by attendance, is also important. If women have to miss three or more CP groups, they should be encouraged to switch to individual appointments. An arrival list is kept and belly checks are done in order of arrival, so those arriving early will leave promptly when the group ends.

Each CP group runs on a calendar schedule of a Week 1&3 or Week 2&4 cycle. This ensures that the same night is available for each CP group on the specific ‘every-4-weeks then every-2-weeks’ schedule. As each CP runs for 24 weeks, only two CPs per year can be held in a particular day/time slot. For example, a CP1A for January EDDs held on a Week 1/3 cycle (for Jan 2013 EDDs, CP 1A starts August 27/12 and ends February 11/13) can roll over into a CP7A for July EDDs (starts Feb 19/13 and ends Aug 6/13). If your facility space limits the number of CP groups that can be held to one per day (or evening), this careful method of scheduling becomes necessary to ensure there is no overlap. If you have access to two group care spaces, this intricate planning is not necessary.

Groups can run successfully with small groups of 5-6 women and their partners, while starting up. Initially, there may be a need to combine EDD months in small communities or until patient volume is sufficient (eg, EDDs in January and February in one CP group).

CP groups are scheduled from CP1 (January EDDs) to CP12 (December EDDs). Women are assigned to their CP group according to their EDD month. Each CP group runs on the same day of the week, at the same time (rescheduling for holidays). Each CP group runs from start to finish for a total ten sessions, over 24 week. The first 4 groups are scheduled four weeks apart; the 5<sup>th</sup> group and every subsequent group thereafter (to the final and 10<sup>th</sup> group) are scheduled every two weeks after the 4<sup>th</sup> group session.

Once CPs are at capacity, each 'due month' can be split into two CP groups; 'A' groups for women due from the 1-15<sup>th</sup> of the month, and 'B' groups for women due on the 16-31<sup>st</sup> of the month. For instance, January EDDs would join CP groups as follows:

- January CP1 A – January 1-16, EDD's
- January CP 1B – January 17-31, EDD's

A CP Tally template for 2013 plus an example of a CP group schedule are included in an attachment to this document called "CBP Templates".

#### HOME AND HOSPITAL POSTPARTUM VISITS

Hospital and home postpartum visits are completed during the day by the on-call provider. The 2<sup>nd</sup> on-call provider will cover the visits if first on-call is too busy.

### 4.7 CHARTING

Contemporaneous charting and care planning is an important aspect of a successful CBP. In order to ensure a smooth handover of care from one care provider to the next, the charting responsibilities in a CBP may be more extensive than some care providers are used to.

The use of EMR is an important communication tool and reduces the number of phone calls and meetings required to plan patient care. All prenatal appointments, CP group visits, phone calls and home visits can be charted in the EMR. Labs and reports can be uploaded into the patients chart, reducing the number of errors that can happen with incomplete records. Handover summaries of on-call shift events can be disseminated through the EMR messaging systems, with more extensive details entered into EMR charts for each client. In a larger team, it can be helpful to assign charts leads.

#### CHART LEADS

Each patient is assigned a chart lead. If the patient is attending CP group care, the chart lead is the physician or midwife facilitating the CP group. The patient will be seen by her



group facilitator for most of her prenatal care after 18 weeks. If the patient is not attending CP group, the chart lead is assigned to a physician or midwife (generally a provider who is not leading a CP group that month). Patients can be assigned for language (eg; Spanish speaking provider) or on the request of a patient or provider. A second chart lead is also assigned to each patient not in CP group. Women are encouraged to book their prenatal care appointments with one of her two assigned chart leads. This enhances continuity of care and thorough review of the chart.

## 4.8 THE BIRTH ROSTER

The Birth Roster spreadsheet tracks every woman in care at the CBP. The chart lead or CP group leaders are identified, as well as ethnicity, language and individual risk assessments. This is an efficient way of tracking how many women are due each month as intakes are ongoing, and to show which and how many women have imminent (or overdue) due dates. As births occur, details can be filled in, and the sheet also serves to provide information on CP group inclusion, languages, past history and current complications.

The birth roster also generates the billing sheets (discussed in more detail below).

An example of a Birth Roster template is included in an attachment to this document called “CBP Templates”.

## 4.9 BILLING MSP

All earnings are pooled into one account and both midwives and physicians sign an MSP “Assignment of Payment” form. This assignment of payment allows billing under individual practitioner’s names but the revenue is paid into the CBP account, not individual accounts (this does not prohibit practitioners from being paid directly if they are working elsewhere). Essentially, services are billed to MSP under the care provider’s name, but the payee is the CBP’s number rather than the care provider’s.

Currently, several CBPs have an alternate billing agreement with the Ministry of Health. If the patient has at least one visit with a midwife in each of the three trimesters of prenatal care, as well as one visit with a midwife during postpartum care, these courses of care can be billed under the midwife. In this scenario, the CBP does not bill fee for service for every visit – midwifery billings occur on a per capita basis in 5 cycles, one billing code for each trimester of pregnancy (1, 2, and 3), one billing code for the birth,

and one billing code for postpartum care. In 2013, the total billing for a complete course of midwifery care in is \$3100. The only exception to this billing rule is for attendance at the birth: this fee must be billed under the provider attending the birth, midwife or physician. In addition, physicians have a code that can be billed for group care, while midwives do not.

### **BILLING SHEETS**

Billing is done by each trimester of care, labour & birth, and postpartum care. Generally, prenatal care is billed under one of three midwifery codes (for 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> trimester), presuming each client has seen a midwife at least once in each trimester; labour and birth is billed either under a midwife or under physician's codes depending on the attendant and the course of the labour and birth; postpartum care is billed under a single code.

The billing is tracked using an Excel spreadsheet, known as the billing sheet. This sheet lists all clients due in a particular month, whether they were seen by a midwife in each trimester (and which midwife that semester was billed under); who attended them in labour and birth; and whether they were seen by a midwife during postpartum care. The billing sheet also tracks clients who have transferred out of care but can still be billed for, as well as clients with SABs.

An example of a billing sheet template is included in an attachment to this document called "CBP Templates".

### **CARE PROVIDER INVOICES**

Care providers submit standard invoices at the end of each month. This invoice includes the number of clinics, CP groups, and on-call shifts that have done in the month. The invoice automatically calculates the total.

There is an example of a standardized Excel Invoice template to help streamline and facilitate invoicing included in an attachment to this document called "CBP Templates".

# 5. APPENDIX

(CLINIC LOGO/ADDRESS/PHONE/FAX)

## REFERRAL FORM

Date of Referral: \_\_\_\_\_ Patient Self Referral

Patient's Name: \_\_\_\_\_  
Last Middle First

Date of Birth: \_\_\_\_\_ PHN: \_\_\_\_\_  
Month / Day / Year

Address: \_\_\_\_\_  
City Province Postal Code

Phone: \_\_\_\_\_  
Home Work Other

Referring Physician: \_\_\_\_\_ Billing # \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

G \_\_\_ T \_\_\_ P \_\_\_ A \_\_\_ L \_\_\_ LMP: \_\_\_\_\_ EDD: By Dates: \_\_\_\_\_  
By Ultrasound: \_\_\_\_\_

Obstetrical History	Significant Medical Problems
_____	_____
_____	_____
_____	_____

**Please FAX the following documentation with this referral:**

<i>Prenatal Records Parts 1 &amp; 2</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pending <input type="checkbox"/>
<i>Prenatal Bloodwork (including Triple Screen)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pending <input type="checkbox"/>
<i>Ultrasound Reports</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pending <input type="checkbox"/>

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_

(for Clinic use only)  
Caregiver: \_\_\_\_\_  
Date of First Appointment: \_\_\_\_\_