SOUTH OKANAGAN SIMILKAMEEN

PRIMARY CARE MATERNITY PROJECT

South Okanagan Similkameen Shared Care Maternity Care Working Group

2014-2018

FINAL REPORT

March 2018

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EXECUTIVE SUMMARY

The South Okanagan Primary Care Maternity Project was initiated as a response to declining family physician numbers and difficulties recruiting and retaining new colleagues. The loss of family physicians and the potential closure of the Primary Care Maternity Clinic (PCMC) would severely impact patients, other maternity provider groups and Penticton Regional Hospital (PRH).

In April 2013, the South Okanagan Similkameen (SOS) Shared Care Steering Committee received funding support from the Shared Care Committee for a primary maternity care project to address this issue. The over-arching goal of the project was to develop a sustainable model of primary care, one that keeps all provider groups practicing and is supportive of patient choice. Achieving that goal took much longer than anticipated due to siloed stakeholders and entrenched issues preventing dialogue.

Analysis of the maternity project through a process lens suggests that the interplay between provider groups required sufficient time for the development of personal and professional trust. Without trust the project could not move forward. Once a critical level of trust was reached cultural preferences and assumptions could be addressed with a focus on creating a shared cultural context, a common knowledge base and community-based problem solving.

The Primary Maternity Care Advisory Committee, comprised of family physicians, midwives, obstetricians, paediatricians, patients, Interior Health and allied professionals developed a South Okanagan Similkameen Maternity Care Community Model consisting of networked stakeholders. This has major implications for the transfer of care for patients and the sustainability of care for providers as both can move more freely in times of emergency or when birth and provider numbers fluctuate.

Embedded in the model is the creation of an inter-disciplinary collaborative maternity clinic at Penticton Regional Hospital. The South Okanagan Maternity Centre will open April 2018 as a pilot project with four family physicians and one midwife. Providers in the clinic intend to pool billings and standardize their practices with the aim of optimizing patient and provider satisfaction, professional scope, and increasing teaching and learning opportunities.

Funding has been secured to aid the transition to the collaborative model and to maintain alignment with provincial initiatives.

INTRODUCTION

Maternity service delivery is in crisis in the South Okanagan Similkameen (SOS). The issue has become more acute over the past few years with the region experiencing a significant decline in family physician involvement in primary maternity care. Heavy call schedules, rapidly increasing insurance costs, compensation challenges and a reduction in patients due to competition by other providers, have all driven family physicians away from the practice.

Currently primary maternity services in the SOS are provided by four family physicians working together at the Primary Care Maternity Clinic (PCMC) located at Penticton Regional Hospital (PRH); an office-based solo family physician from Oliver; four midwives at Willow Community Midwives clinic; and four independent obstetricians. The number of births has remained almost constant over recent years, but the distribution of those births has changed significantly **(Appendix A: Births by MRP).**

It was recognized that the impact of losing family physicians from primary maternity care in the SOS would impact the entire community and include:

- Decreased options for all patients who choose to have a family physician as a provider.
- Loss of a physician group that provides on call emergency obstetrical care for the majority of unattached, vulnerable and rural patients.
- Closure of the PCMC at PRH and reduction in Interior Health (IH) support positions.
- Increased pressure for obstetricians to take primary care patients which could affect wait times for non-obstetrical consults.
- Inability to attract new maternity providers to the community.
- Loss of a teaching and mentoring resource for family medicine residents, medical and nursing students in a primary care setting (PRH being one of the few hospitals in the province where this is possible).
- Increased number of patients receiving inadequate prenatal care resulting in the potential for complications during pregnancy and delivery.
- Increased number of patients choosing to leave Penticton for their prenatal care and delivery resulting in even lower volumes of deliveries in Penticton.

The Inception of a Shared Care Project

In 2013, the SOS Shared Care Steering Committee received funding support from the provincial Shared Care Committee for a primary maternity care project to address this issue. Local Shared Care project leads met with maternity care service providers to further clarify the issue(s), identify stakeholders and develop a Shared Care Primary Maternity Care Advisory Committee. The Committee included family physicians, midwives, obstetricians, paediatricians, patients, Interior Health and allied professionals.

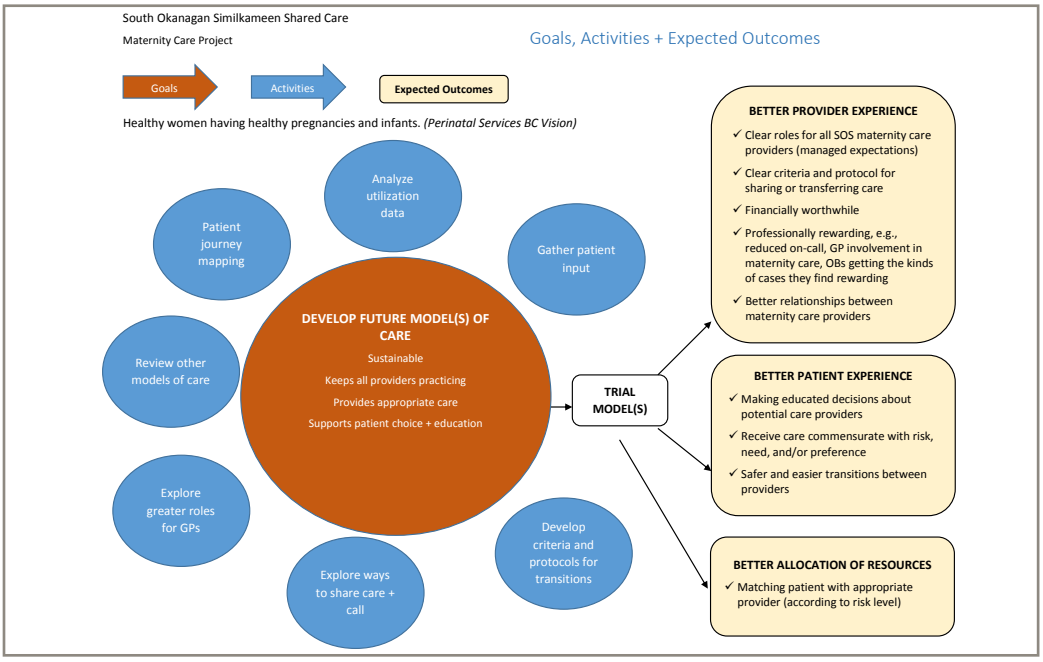
The number of Committee members was intentionally limited to encourage candid discussion in an environment with a known low level of trust. However, that number increased as stakeholder relationships improved and engagement became a necessary part of the solution.

GOALS

The overriding goal of the project was to collaboratively develop a future model of maternity care for the SOS. During the early stages of engagement it was clear that the depth and entrenchment of outstanding issues between stakeholder groups and individual committee members would make defining detailed goals a challenge. Unable to find common ground, it was decided that a logic model should replace a formal charter so that the project could follow a more iterative approach thus allowing the group to explore options before committing to any pre-conceived outcomes.

The initial logic model (March 2014) provided structure for the activities of the group. It showed the projects goal (orange); activities thought to provide necessary information gathering and allow for relationship building (blue); and expected outcomes (beige).

Figure 1: Logic Model Version One



Goals from Logic Model Version One

- Sustainable
- Keeps all providers practicing
- Provides appropriate care
- Supports patient choice and education

Three subsequent versions of the logic model added goals that reflected discussion by the group often linked to new activities (that helped with relationship building) and resulted in a refinement of expected outcomes from the project. Version 2 of the Logic Model was created in July 2015; Version 3 in April 2016; and Version 4 in September 2016 **(Appendix B: Logic Models Versions 1, 2, 3 and 4)**.

PROCESS

The additional goals from these subsequent logic models included:

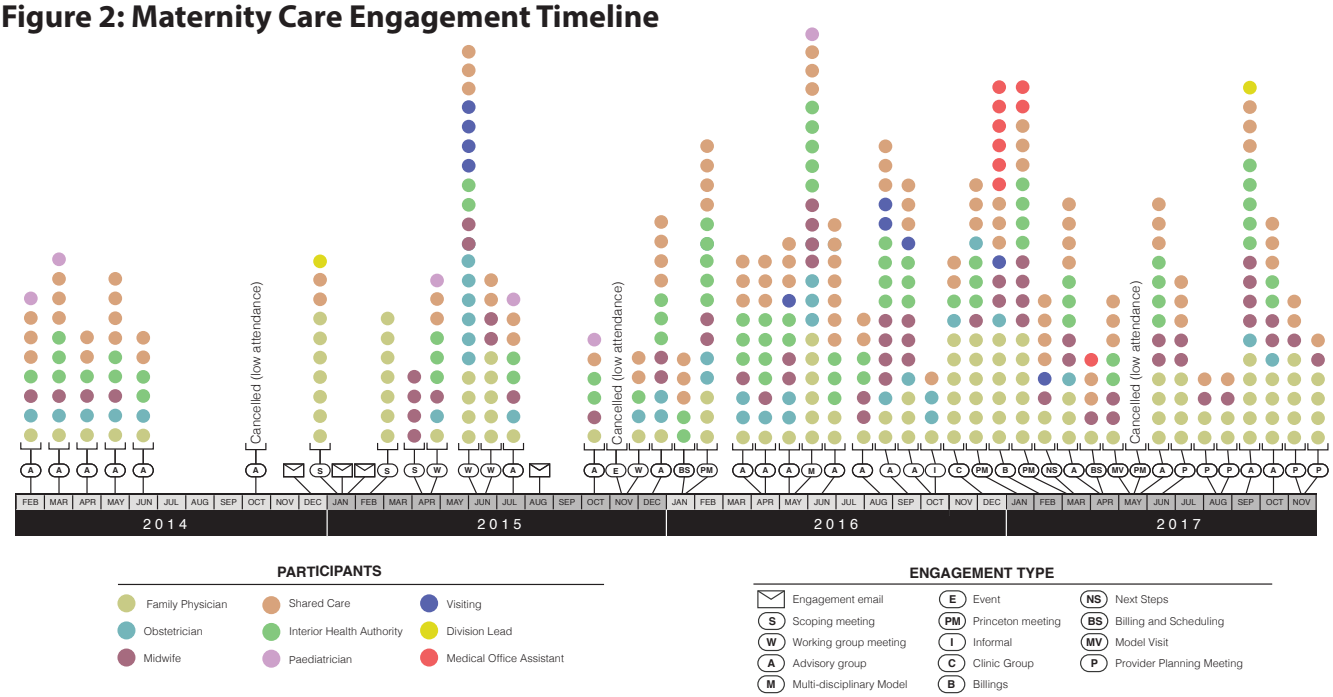
- Referring FPs and patients know the "Model of Care" (Version 2)
- Clarifies expectations (respective roles, responsibilities and patient transitions) (Version 2)
- Continuity of care (Version 2)
- Patient Pathways (Version 3)
- Connects maternity patients with right provider, right care at the right time (Version 4)
- Sustainable for the long-term (Version 4)
- Administratively "do-able" (Version 4)

Due to the lack of a collaborative culture in primary maternity care, a developmental approach was used to evaluate the SOS maternity project. The project moved forward in a series of iterative steps linked by continuous feedback and analysis. Siloed care providers needed to find some common ground in order to begin moving forward. Mapping of the patient pathway from pregnancy confirmation to 8 weeks post-natal provided the starting point for dialogue around clinical similarities and differences. As the project progressed the dialogue focused on care practices, transfers of care, consults and options to share care.

ENGAGEMENT

A coded timeline was introduced as a way of thematically understanding the mechanisms, dynamics and outcomes of the group over time, as well as to better understand the group make up and participation commitment levels. Participants were coded by their different roles (provider groups, physician lead, project management, visiting reps), and mapped out against their attendance and participation in meetings that have been held over the past four years.

Figure 2: Maternity Care Engagement Timeline



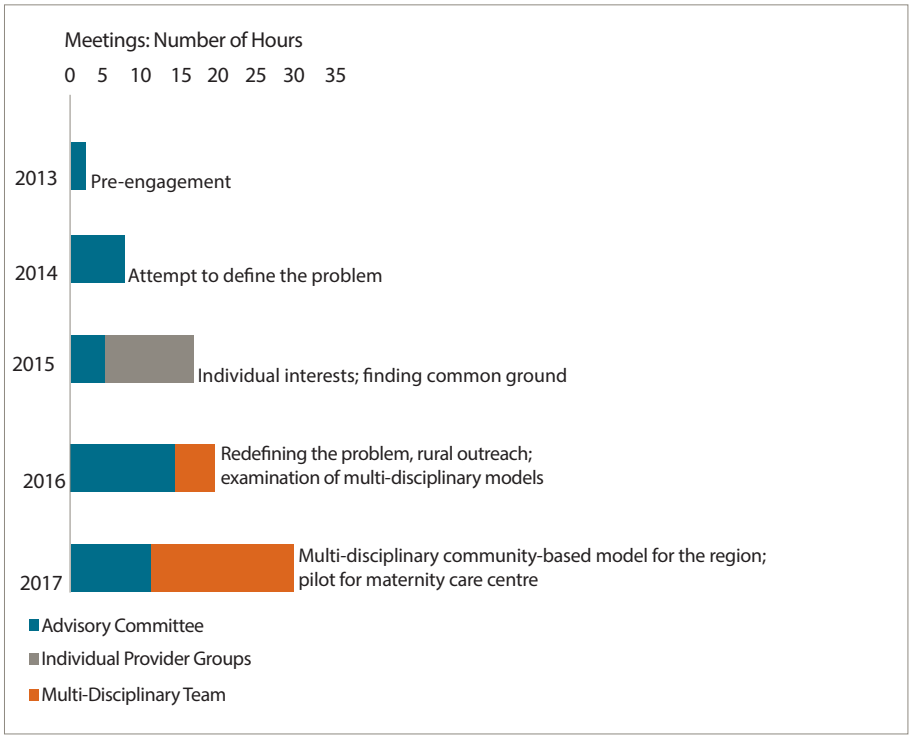
PROCESS

When examining the timeline, certain points of interest become apparent in the visualization:

- Difficulty establishing traction with the group as a whole inter-disciplinary team
- Gaps in time between meetings and low attendance often due to capacity issues and a shortage of adequate maternity coverage
- Shift from varying participation levels across all the provider groups to increased commitment from a core group of devoted practitioners to support the development of a new model
- Possibility of identifying actions taken by the group that helped to re-invigorate interest and commitment as well as highlight the shift to a more collaborative mindset
- Hearing from visiting practitioners that using the philosophical approach "The Art of the Possible" was a way forward
- Examination of successful inter-disciplinary care models with alternative billing options
- Connections to the GPSC and Perinatal BC maternity initiatives and attendance at workshops
- Working as a multi-disciplinary team to help rural sites with transitioning patients and providing emergency training

Although group membership ebbed and flowed over the four years of the project, the frequency and duration of meetings increased. The emergence of provider champions was key to engaging the wider provider groups. As the meetings became increasingly inter-disciplinary, the outcomes became more community focused.

Figure 3: Stakeholder Participation and Engagement



PROCESS

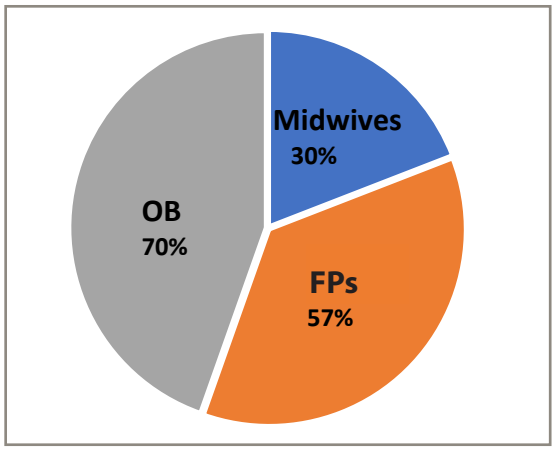
TRUST

Provider surveys and participant interviews were used to solicit feedback from the group to move through sticking points (2015, 2016 and 2017). Differences in care practice by providers were discussed many times over the four years, in both formal and informal settings. For much of the project these differences acted as stumbling blocks to compromise and appeared to prevent providers coming together to design a collaborative model for the South Okanagan Similkameen (SOS), which would allow them to practice in their preferred way.

Analysis of the maternity project in the SOS, through a process lens, suggests significant time was required for the development of personal and professional trust because of the lack of interplay between provider groups. Once silos started to break down and trust levels increased, the group was able to become creative, manage conflict, work as a team and empower individuals to become leaders during times of uncertainty in the collaboration process.

A survey ranking trust levels was used to assess the change in individual provider trust with all other providers in the maternity group **(Appendix C)**. Aggregated results show on average a 60% increase in trust between all providers over the course of the project.

Figure 4: Increased Provider Trust



The differences between provider groups could be explained by the lack of baseline knowledge and remnants of entrenched views on practice differences.

In 2017 one practitioner summarized the current level of understanding:

"We know what each of us want. We've absolutely built relationships. There's a really good understanding of the maternity care we're providing and what we all need to practice."

PROCESS

Personal and professional relationships increased trust levels to allow the group to answer difficult questions:

What do providers want?

In June 2017 all maternity providers were requested to complete a provider survey **(Appendix D)**. Providers were asked individually about their motivations and intentions for practicing maternity care. Work-life balance was examined by asking them about their ideal, minimum and maximum number of call and clinic shifts and their needed baseline income levels.

Motivations for participating in any new model varied, but those who were interested in the new model wanted to improve their work life balance, increase their revenue, provide continuity of care, increase their opportunities to collaboratively work with and learn from their colleagues, increase their scope of practice, and ultimately provide an enhanced service and choice to the women being served.
Concerns from providers ranged, but included reticence and apprehension of change, the loss of home births and maintaining an appropriate income/overhead ratio. These concerns/limits and goals were set as the foundation for developing the new model.

Sample quotes from the provider survey:

Concerns: *"Uncertain of a new model. Lots of added administration work. Less time at home."* — Family physician

Motivation: *"Call schedule, learning from others, change in practice to reinvigorate myself."*— Midwife

What do patients want?

A survey was widely distributed to patients in all provider group and community public health offices/ services throughout SOS **(Appendix E)**. It was available online and in hard copy. A total of 177 responses (91 online) were received with a representative number from all provider groups. The survey looked at patient motivation, choice of care, perceived quality of care and thoughts on a dream maternity care model.

Patient's Dream Model:

- Post-natal home visits
- Continuity of care (fewer providers)
- Part of a women's health clinic
- Hospital births
- Longer appointment times
- A clinic space in a neighbourhood setting

Sample quotes from patient survey:

"The best thing about my care was the long appointments — feeling all my concerns were addressed, and having wonderful, caring midwives." — Midwife patient

"Friendly; easy to change appointments; quick." — PCMC patient

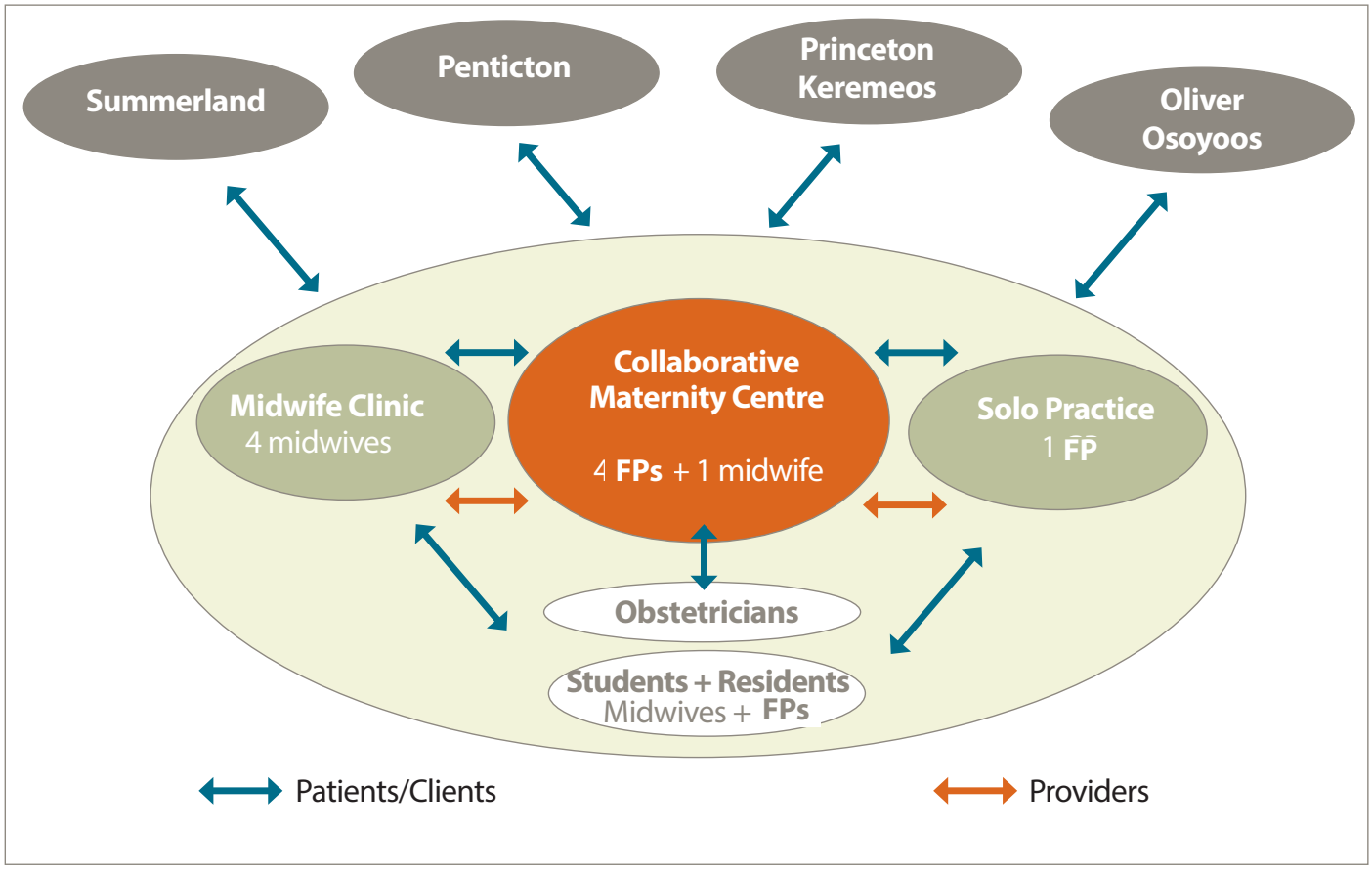
PROCESS

CULTURE CHANGE

Steven M.R. Covey in his popular business culture book *The Speed of Trust* says that when the level of trust is raised, the speed of change also goes up. Trust is both a choice and a process and it is clear that individuals and provider groups involved in primary care maternity care in the SOS arrived at the necessary level at different times. Once a critical level was reached cultural preferences and assumptions could be addressed with a focus on creating a shared cultural context, a common knowledge base and community based problem solving.

Trust makes cultures *change ready*. Once trust had been established the Primary Maternity Care Advisory Committee was able to design the South Okanagan Similkameen Community Care model, which in practice achieves the initial goals of the group.

Figure 5: South Okanagan Similkameen Community Care Model



PROCESS

The community care model utilizes the network of maternity providers. Increased trust allowed for the creation of a common knowledge base and standardization of care. This has major implications for the transfer of care for patients and sustainability of care for providers as both can move more freely in times of emergency or when birth and provider numbers fluctuate.

Embedded in the community model is the development of a collaborative, multi-disciplinary clinic, The South Okanagan Maternity Care Centre, which will allow patients to benefit from the collaborative practice of family physicians and midwives in one facility in PRH. The Maternity Centre is scheduled to open April 1st as a one year pilot at PRH.

Benefits of the Model for Patients:

- Increases range of options for primary care in the SOS — with an easily accessible resource providing information on all options
- Provides patients with the type of care they are requesting (as per the results of the patient survey)
- Educates referring FPs so they can provide the best advice their patients
- Standardizes patient pathway protocols and patient education will improve continuity of care for all patients
- Networks maternity professionals (family physicians, midwives, obstetricians, paediatricians, social workers and allied health care givers) providing wrap-around care
- Maintains a primary maternity care clinic that caters to unattached and marginalized patients and babies

Benefits of the Model for Providers:

- Determines the correct number and mix of practitioners needed to sustain all providers in the community
- Provides flexibility in the system if one of more provider group needs help, and has more opportunities for cross-coverage
- Allows providers to practice the way they want
- Improves the work-life balance of family physicians and midwife providers
- Is the type of obstetrical primary care, which is more attractive for the recruitment of new providers
- Allows a collaborative team to work at top of their scope and coach and learn from each other.
- Allows opportunities for collaboration with other disciplines in the community maternity network in order to share care and provide learning opportunities
- Maintains the opportunity for students and residents to experience primary obstetrical training at PRH

DELIVERABLES/ACCOMPLISHMENTS

Maternity Care Options in the South Okanagan Similkameen

The Advisory Committee saw a need for a resource that allows patients to easily find maternity care options in the South Okanagan Similkameen. The Committee has contributed to the development of a community website, which introduces patients to the care given by all provider groups (collaborative clinic, midwives clinic, solo FP and obstetricians) and their contact information as well as links to other useful resources for mothers and babies **(www.pentictonmaternity.com).** Print brochures containing a summary of primary care options will be available for referring family physicians to give to their patients (draft in progress).

Transfer of rural patients

All babies in the South Okanagan Similkameen must be delivered in Penticton Regional Hospital (other than home births) so the transfer of patients is a crucial part of the patient pathway. The Advisory Committee in collaboration with family physicians from Princeton, produced a brochure to aid patients make the transfer by following a clear pathway from their local care team to the wider maternity team in Penticton **(Appendix F)**.

The South Okanagan Maternity Centre will open as a one -year pilot at Penticton Regional Hospital (PRH) in April 2018. The clinic will run with four family physicians and one midwife and be networked directly to obstetricians, a perinatal social worker, paediatricians and other maternity professionals.

As the only Interior Health facility providing hospital births in the region, PRH is the hub for the majority of pregnant women. The Maternity Centre will provide direct care to a higher than average number of unattached and marginalized mothers and babies. In this team-based clinic, providers, patients and staff will benefit from wrap-around care, clear care pathways, common protocols and patient handouts developed by the clinic team (and shared with the maternity network) and a clear understanding of roles and responsibilities. In order make the clinic sustainable, family physicians and midwives will pool billings.

The clinic intends to foster provider education and knowledge sharing, for example the midwife is scheduled to take a C-section assist course in 2018 and an obstetrician has agreed to act as mentor. The inter-disciplinary clinic will provide a teaching venue to promote obstetrical care to both physician and midwife students and residents.

Patient survey results indicated the desire for mothers to include partners in their pregnancy journey. Once the inter-disciplinary team of providers is comfortable working in the shared-care clinic model, future plans include offering postnatal home visits and developing a series of group medical visits in order to introduce the patient and her family to the maternity team.

In 2019 the South Okanagan Maternity Centre will move into a dedicated space in the new care tower at PRH. Physicians, midwives, obstetricians and IH care workers have all been involved in its design to ensure patient comfort and clinical efficiency.

CHALLENGES

Entrenched issues and deep divides between provider groups significantly slowed the process of developing a working solution to the problem. The need for change and the development of a shared care model was agreed upon in early discussions, yet it took four years to bring the project to fruition. It took time to develop personal and professional trust before the group could rally around a common theme and look at ways of working together in an attempt to make each group sustainable. The challenge and process of building trust to create culture change was presented in a storyboard format at the 2018 BC Quality Forum **(Appendix G)**.

Although the process was slow, the building of personal and professional trust allowed primary maternity providers to come together to work on common problems. In this photo, family physicians, obstetricians and a midwife came together to provide rural outreach for Princeton maternity patients transferring to Penticton Regional Hospital.

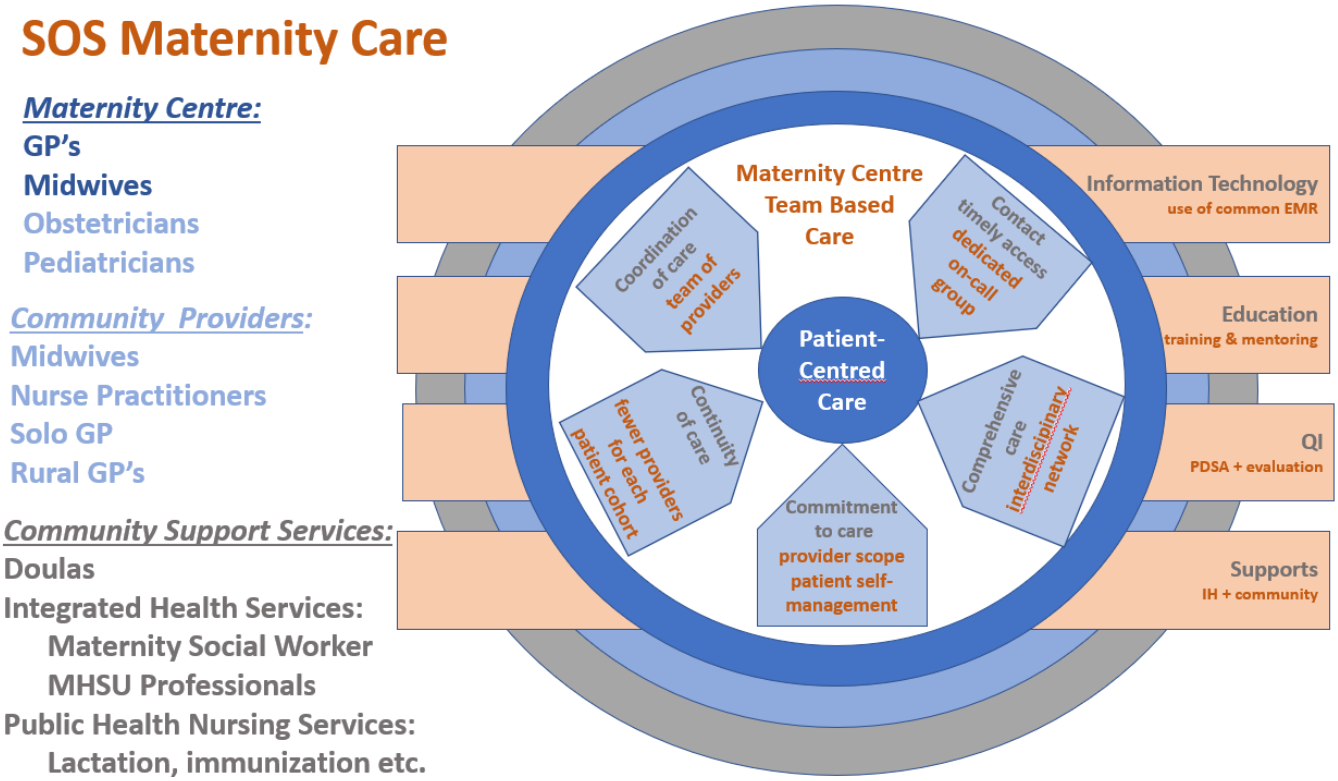
NEXT STEPS

The project has received $25,000 in physican sessional funding from the Penticton Physician Medical Society to help run the pilot (April 1st 2018 - 31st March 2019). Funding was requested to support the transition to this new inter-disciplinary team-based approach to care within PRH. The focus will be on developing and implementing protocols designed to utilize the collective knowledge of the team and to standardize care.

The project has received $25,000 in funding from the Shared Care Committee to continue the spread of the work of the maternity project to date by:

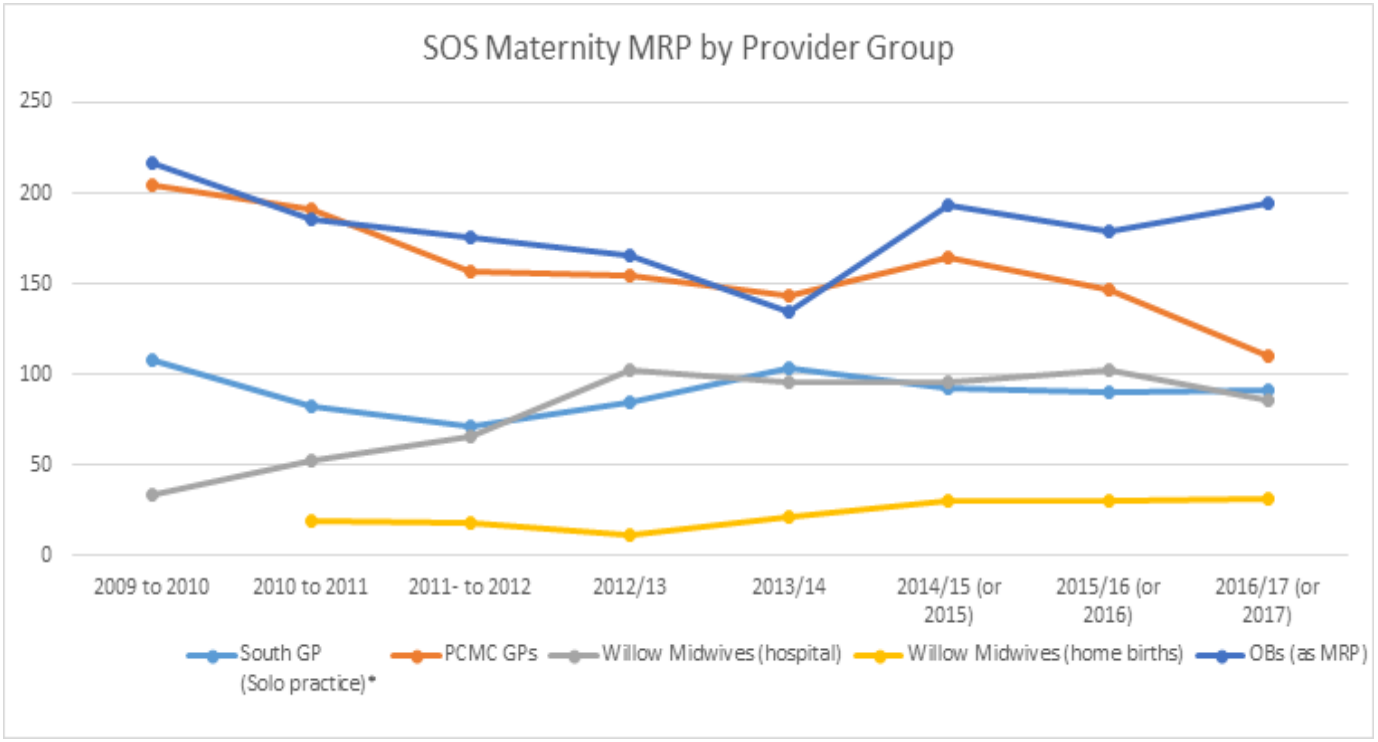
- Maintaining and fostering the local network of care providers. The South Okanagan Similkameen Maternity Model aligns with the development of Patient Medical Homes (PMH)/PrimaryCare Networks(PCN) in our community.
- Maintaining this maternity care model as a key part of our communities' Primary Care Network.

Figure 6: SOS Maternity as a Primary Care Network



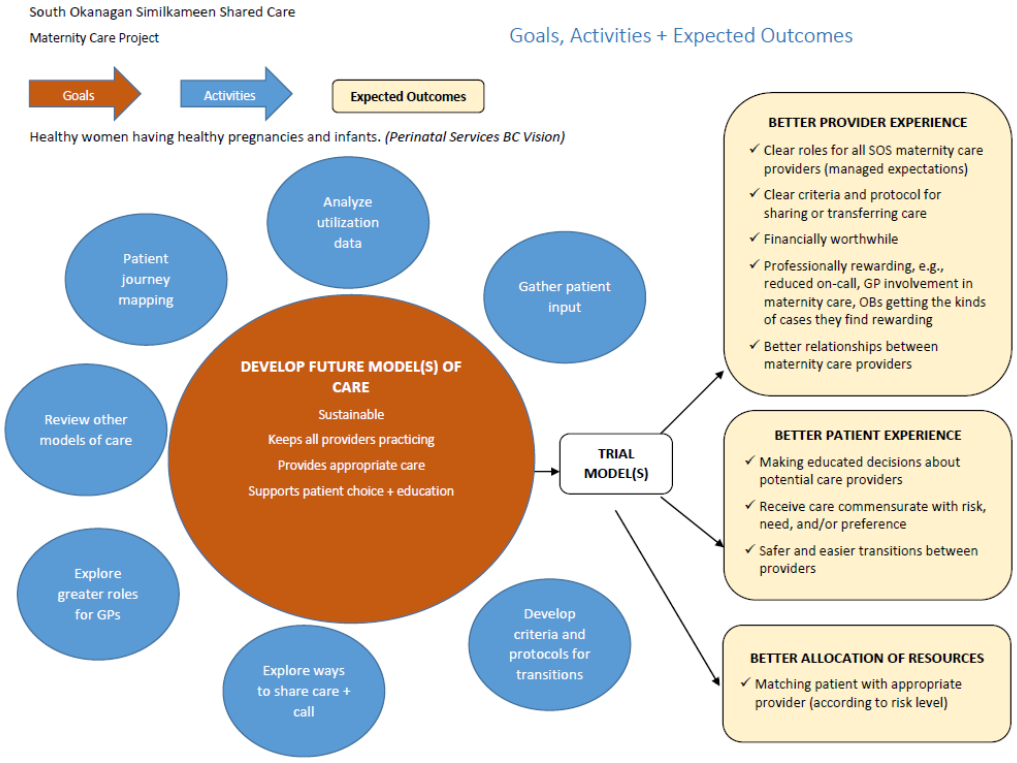
- Continuing to align with the Provincial Maternity Initiative and Perinatal Services BC who are promoting inter-professional collaborative practices as an effective and efficient way to improve the quality and sustainability of primary maternity care.

APPENDIX A

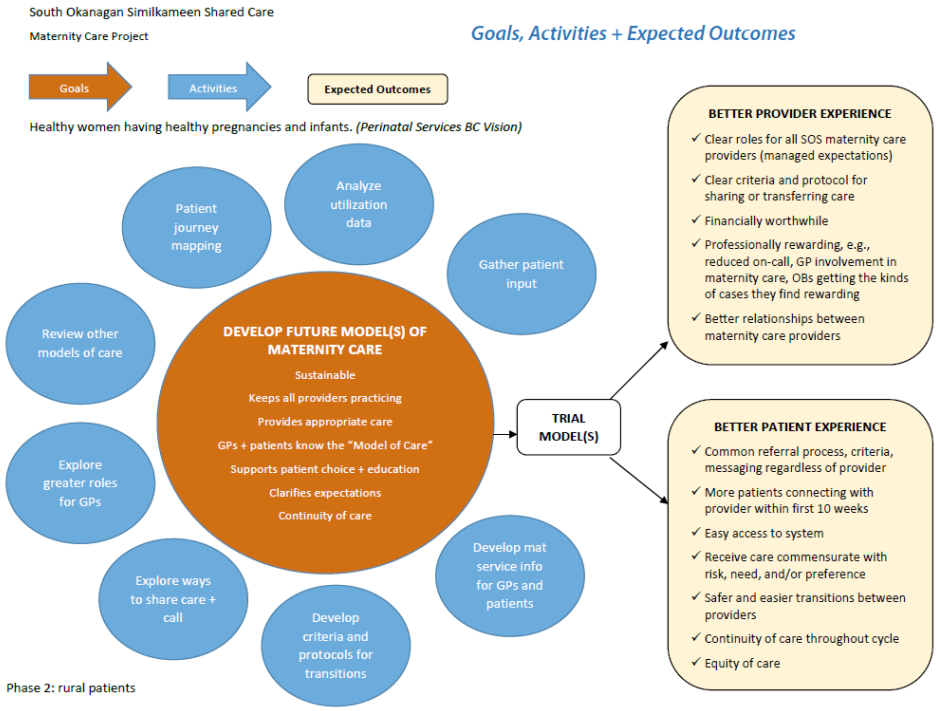

SOS Maternity MRP by Provider Group
250
200
150
100
50
0
2009 to 2010
2010 to 2011
2011- to 2012
2012/13
2013/14
2014/15 (or 2015)
2015/16 (or 2016)
2016/17 (or 2017)
South GP (Solo practice)*
PCMC GPs
Willow Midwives (hospital)
Willow Midwives (home births)
OBs (as MRP)

APPENDIX B

Logic Model: Version 1 (March 2014)

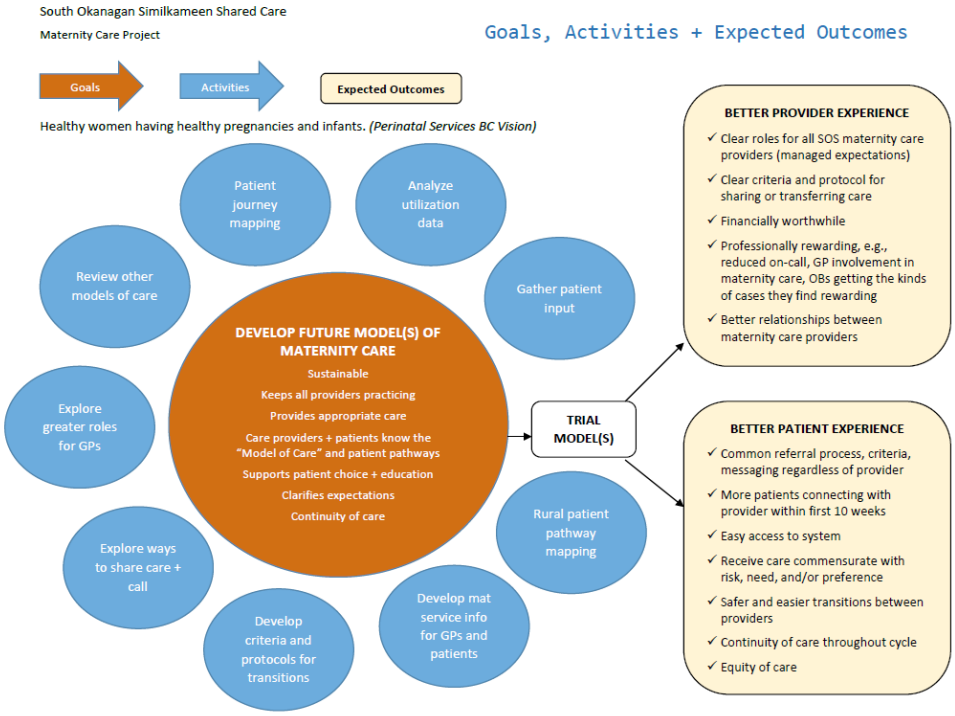


Logic Model: Version 2 (July 2015)

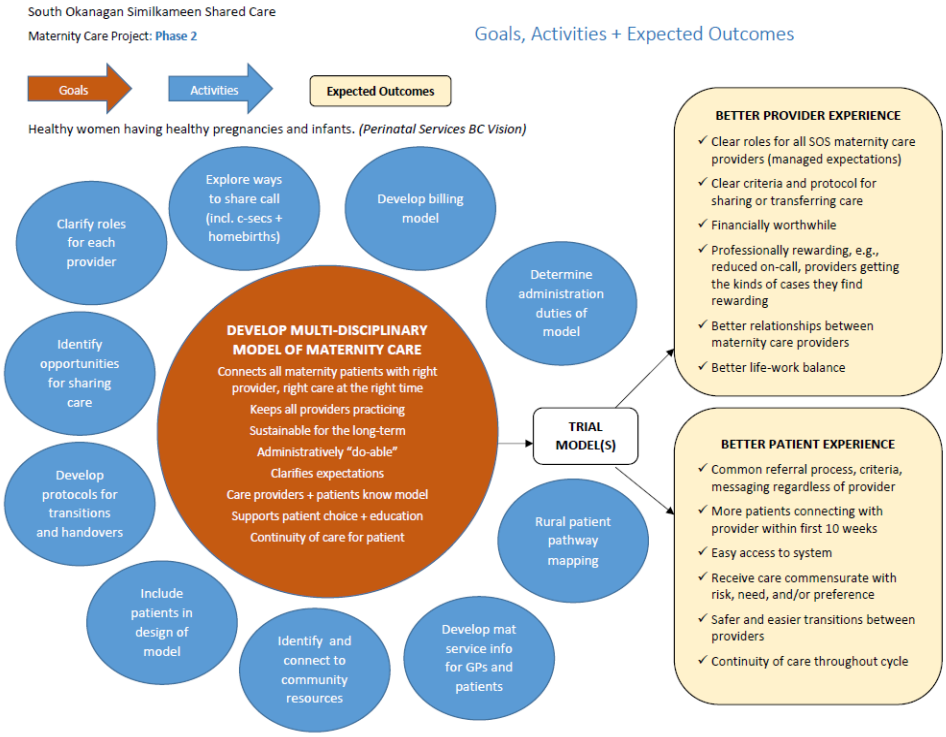


APPENDIX B

Logic Model: Version 3 (April 2016)



Logic Model: Version 4 (September 2016)



APPENDIX C

Provider Trust Survey – Example of Question Sheet

Name		Status	Very low	Low	Somewhat low	Neutral	Somewhat high	High	Very High
Physician #1	This is me ☐	**When I started this work...**	I had a very low level of trust with this person ☐	I had a low level of trust with this person ☐	I had a somewhat low level of trust with this person ☐	I neither trusted nor distrusted this person ☐	I had a somewhat high level of trust with this person ☐	I had a high level of trust with this person ☐	I had a very high level of trust with this person ☐
		Now	I have a very low level of trust with this person ☐	I have a low level of trust with this person ☐	I have a somewhat low level of trust with this person ☐	I neither trust nor distrust this person ☐	I have a somewhat high level of trust with this person ☐	I have a high level of trust with this person ☐	I have a very high level of trust with this person ☐
Midwife #1	This is me ☐	**When I started this work...**	I had a very low level of trust with this person ☐	I had a low level of trust with this person ☐	I had a somewhat low level of trust with this person ☐	I neither trusted nor distrusted this person ☐	I had a somewhat high level of trust with this person ☐	I had a high level of trust with this person ☐	I had a very high level of trust with this person ☐
		Now	I have a very low level of trust with this person ☐	I have a low level of trust with this person ☐	I have a somewhat low level of trust with this person ☐	I neither trust nor distrust this person ☐	I have a somewhat high level of trust with this person ☐	I have a high level of trust with this person ☐	I have a very high level of trust with this person ☐
Obstetrician #3	This is me ☐	**When I started this work...**	I had a very low level of trust with this person ☐	I had a low level of trust with this person ☐	I had a somewhat low level of trust with this person ☐	I neither trusted nor distrusted this person ☐	I had a somewhat high level of trust with this person ☐	I had a high level of trust with this person ☐	I had a very high level of trust with this person ☐
		Now	I have a very low level of trust with this person ☐	I have a low level of trust with this person ☐	I have a somewhat low level of trust with this person ☐	I neither trust nor distrust this person ☐	I have a somewhat high level of trust with this person ☐	I have a high level of trust with this person ☐	I have a very high level of trust with this person ☐

SharedCare
Partners for Patients

Scheduling/Billing Questionnaire – Maternity 2017

I am a: x GP ☐ OB ☐ MW

Why are/were you practicing (or intending to practice) maternity care?

If you are not currently practicing, do you intend to return/start? If so, when?

What are your plans for continuing to practice maternity care? Ideally how much longer would you like to practice?

Would you like to change the way and volume you currently practice?
Please give reasons for your answer.

Do you feel as though you're currently working at your top of scope? How could this change?

Please give rough answers to the following work/life balance questions (where applicable):

	Min.	Max.	Ideal
# 24-hour Call (in 4 week time period)			
# Clinic (in 4 weeks)			
# Group medical visit (in 4 week time period)			
$ Net income/call shift			
$ Net income/clinic shift			
$ Net income/GMV			
Overall monthly net maternity income			
Overall monthly days off (if applicable)			

Are you interested in pursuing a collaborative care model? ☐ Yes ☐ No ☐ Potentially

What are your concerns about implementing a collaborative model? What is the biggest concern?

What is your biggest motivation? How could this be supported?

APPENDIX D

What do you feel will be the biggest challenge? How could this be mitigated?

Would you be willing to work in a different location? ☐ Yes ☐ No ☐ Potentially

Why or why not? What concerns do you have?

Would you be willing to work a combined clinic/on-call shift? ☐ Yes ☐ No ☐ Potentially

What concerns do you have about working separate clinic/call shifts?

What concerns would you have about working a combined (on-call/clinic) maternity shift?

Would you be willing to lead or co-facilitate a group medical visit?

☐ Yes, happy to lead ☐ Likely yes, happy to co-facilitate ☐ May consider w/ appropriate supports

☐ Likely not, a bit out of my comfort zone ☐ Definitely no

My interest in doing home visits:

☐ Yes, absolutely ☐ Interested, need training ☐ Curious, need more information

☐ Likely not, a bit out of my comfort zone ☐ Definitely no

My interest in doing home births:

☐ Yes, absolutely ☐ Interested, need training ☐ Curious, need more information

☐ Likely not, a bit out of my comfort zone ☐ Definitely no

What developments in maternity care would you like to see happen in the South Okanagan over the next 5 years? Do you have any other concerns/comments/issues?

Please feel free to include any additional comments you may have.

APPENDIX E

SharedCare
Partners for Patients

Maternity Patient Survey

Thank you for doing this 2 minute survey! Your input will help us to better understand what is important to you and why people chose a particular type of maternity care.

Your survey is confidential and won't been seen by your care providers.

When I had my baby I lived in (e.g., Penticton, OK Falls)?
_____.

(If applicable): I delivered ☐ at the Penticton Hospital ☐ at the Kelowna Hospital ☐ at home ☐ Other:_____

Currently I am in my: ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ gave birth within 2 years

This is/was my _____ pregnancy (e.g., first, second, third, etc.).

*If I received maternity care before, they primarily included *(if applicable, please check all that apply):*

☐ Obstetrician	☐ Midwife	☐ Family Physician
☐ Nurse Practitioner	☐ Primary Care Maternity Clinic (PRH)	☐ Other: _____

\I was referred to my maternity care by:*

☐ My family doctor	☐ Nurse Practitioner	☐ No referral, I came myself
☐ Walk-in Clinic/Emergency	☐ Midwife	☐ Other: _____

Would you recommend the care to your friends or other expectant mothers?	Absolutely would not recommend	Would not recommend	Indifferent	Would recommend	Strongly recommend	N/A

Please rank your top **five** reasons for choosing your most recent experience of maternity care.	Most important	Second most important	Third	Fourth	Fifth
Location of clinic.					
What the clinic space feels like.					
How easy it was to make an appointment.					
I want to be cared for by one person.					
I want to be cared for by a group.					
Type of care provided (midwife, physician, obstetrician)					
I wanted/want to plan for a home birth.					
I already knew my care providers personally (e.g., friend, neighbour).					

(Please continue on the other side)

I had been care for by my provider before.					
I wanted longer appointments.					
I wanted/needed specific services.					
I wanted a close relationship with my care provider/s.					
Advice/experience of my friend/family.					
I did some research online.					
I was sent there by another care provider.					
Other: _____ _____					

Why did you choose to see the care providers you did during your pregnancy?

_____
_____
_____

The best thing about the care was …

_____
_____
_____

If I could change one thing about the care it would be…

_____
_____
_____

If you were designing your **dream experience** for maternity care, how likely would it be to include the following kinds of things…?

	Very Likely	Likely	Maybe	Unlikely	Very unlikely
Group visits with other pregnant women.					
A clinic space in the hospital.					
A clinic space in a neighbourhood setting.					
Home births.					
Hospital births.					
Post-natal home visits					
Part of a women's health clinic that provides all types of services (e.g., PAPs, family planning, sexual health)					
Follow-up group visits with other new parents					
Long appointment times (30 minutes)					
Short appointments (15 minutes)					

Different types of providers (midwives, doctors, nurses)					
One provider most of the time.					
Other: _____ _____					

Can we contact you to participate in a follow-up interview or focus group?

Name: _____

Phone: _____

Email: _____

Additional comments

_____
_____
_____
_____
_____

Thank you for your participation and input!

APPENDIX F

Meet your teams...

Cascade Medical Clinic
98 Ridgewood Drive
Princeton, BC V0X 1W0
Tel: 250– 295-4482

South Okanagan Maternity Centre
550 Carmi Avenue
Penticton, BC V2A 3G6
Tel: 250-492-4000 (ask for the Maternity

Willow Community Midwives
601 Martin Street
Penticton, BC V2A 5L5
Tel: 250-276-6088
Fax: 250-276-6101
Website: www.willow-midwives.ca
Info@willow-midwives.ca

Maternity Care in Princeton

Caring for a mom and her baby during and after pregnancy is one of the highlights of many doctor's practice. Here in Princeton prenatal care is a team effort!
Princeton General Hospital is **not equipped** to deliver babies so the doctors and nurse practitioners here in Princeton have teamed up with the doctors and midwives in Penticton to ensure you and your baby have a healthy pregnancy and safe delivery.

Your Journey

This pamphlet is to introduce you to your pregnancy care team and help guide you through your pregnancy journey.

South Okanagan Maternity Care: Building Trust to Create Culture Change

DEFINING THE PROBLEM

The number of family physicians wanting to practice maternity care in the South Okanagan was in decline

In 2014, maternity care in the South Okanagan was in crisis.

- The family physician presence was in decline due to compensation challenges, competition, high insurance rates and long hours.
- Maternity care providers worked in isolation, with a notable lack of personal and professional trust between individual provider groups, and with other health care professionals.

FINDING A COMMON APPROACH

Various professionals and maternity care providers formed an Advisory Committee

To find a common approach to the problem, an Advisory Committee, which included family physicians, midwives, obstetricians, paediatricians, patients, Interior Health and allied professionals was assembled.

Initially unable to come to any consensus around a formal project charter, the Committee embarked on an iterative path to identify common goals, activities and expected outcomes.

SETTING GOALS

The Advisory Committee agreed that a future model of maternity care must incorporate the following goals:

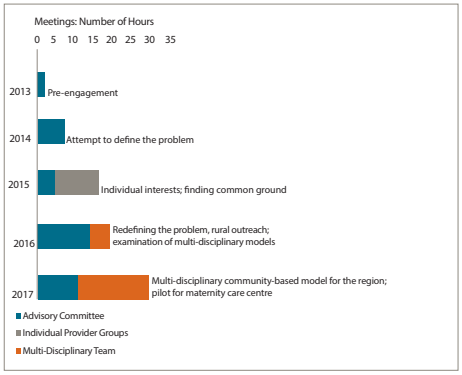
- **Be sustainable**
- **Maintain patient choice, and be based on patient needs**
- **Keep all providers practicing**
- **Allow for better work/life balance for all providers**
- **Allow for flexibility, cross-coverage, and ease of transfer of care**
- **Ensure that physicians and patients are educated about care options**

BUILDING TRUST

The initial level of trust amongst providers was unable to support the changes necessary to achieve the agreed-upon goals.

However, multi-disciplinary stakeholder meetings allowed for relationship building to take place. Meeting frequency, participation and engagement increased over time.

STAKEHOLDER PARTICIPATION AND ENGAGEMENT



Lack of trust is a major barrier to organizational culture change. Building trust is both a choice and a process, and low levels result in slow culture change.

— S.R. Covey, *The Speed of Trust*
(Simon & Schuster 2006)

Personal and professional silos started to break down as trust levels increased. Trust allowed providers to become creative, manage conflict, work as a team and empower individuals to become leaders during times of uncertainty in the collaboration process.

COLLABORATIVE TRUST BUILDING ACTIVITIES

- **Examination of several collaborative care models, with input from the GPSC maternity initiative, Perinatal BC, and other successful community maternity clinics**
- **Mapping of clinical pathways used by all South Okanagan maternity care providers, in order to identify commonalities**
- **Development of patient and provider surveys to inform community needs**
- **Examination of BC maternity billing options**
- **Multi-disciplinary team teaching opportunities**
- **Collaborative planning for new Penticton Regional Hospital maternity unit**
- **Participation at multi-disciplinary care workshops**

"We are dedicated to creating a service that is derived from what women want. We are dedicated to our community of care providers, so everyone can practice how they wish."
— Local midwife participating at multi-disciplinary care workshop
Perinatal Services BC, Vancouver, May 2017

60% **Average increase in trust amongst provider groups from 2014 -2017**

CULTURE CHANGE

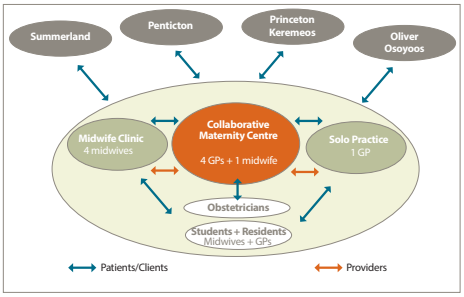
Once trust was established, cultural preferences and assumptions could be addressed, and community problem solving could begin. In late 2017 the Committee designed a South Okanagan Community Maternity Care Model, which achieves all the initial goals of the project.

Based on the strength of relationships and the flexibility inherent in a networked environment, patients are more easily transferred and providers become interchangeable in times of emergency.

Embedded in this model is a collaborative clinic, the South Okanagan Maternity Centre, which will soon be based at Penticton Regional Hospital.

This maternity care model provides incentives to maintain and build relationships as maternity care professionals continue to learn from each other.

SOUTH OKANAGAN COMMUNITY MATERNITY CARE MODEL



DELIVERABLES

COMMUNITY RESOURCES FOR MATERNITY CARE OPTIONS

The Advisory Committee is overseeing the creation of a community website, which provides details on all maternity care options in the region.

Print brochures containing referral and rural transfer protocols are also being produced.

South Okanagan Maternity Centre

The South Okanagan Maternity Centre will be located at Penticton Regional Hospital, starting April 2018.

One midwife and four GPs, who will be networked directly to obstetricians, a perinatal social worker, paediatricians and other maternity professionals, will provide wrap-around care.

As the only Interior Health facility providing hospital births in the region, this hospital is the hub for the majority of pregnant women. The Maternity Centre will provide direct care to a higher than average number of unattached and marginalized mothers and babies.

In this team-based clinic, providers, patients and staff will benefit from clear care pathways, common protocols and an understanding of roles and responsibilities. Education and training are built into the development and sustainability of the clinic.

CONTACT INFORMATION

CONTACT INFORMATION

Shared Care Projects

South Okanagan Similkameen

Division of Family Practice

tel: 778-476-5696

info@sosdivision.ca