Throughout the province, midwives collaborate across disciplines, strengthening maternal and newborn care.

Members of the Temiskaming Hospital maternity care team: (left to right) Kim Cloutier Holtz, RM; Dana Cherniatenski, RN; Dr. Peter Pace; Dr. Steve Sears; Dr. Glenn Corneil and Joan Brazeau, clinical nurse manager.
As a practicing midwife, my work intersects with other health care professionals often. I value and nurture collaborative relationships and encourage my midwifery colleagues to get involved with hospital committees, provincial projects or community-based efforts to improve maternity care by sharing with doctors, nurses, pharmacists, radiologists, social workers, dieticians and anyone involved with caring for women and babies.

Midwives interact with a wide variety of health care workers and social services workers on a daily basis in order to provide optimal care for clients. From hospital rounds to provincial maternal care committees to work in the community, midwives consult with, learn from and teach other providers (see infographic, pages 6 & 7).

This interprofessional collaboration leads to myriad benefits for clients, the professionals involved and Ontario’s health care system as a whole. Health care professionals gain insights from each others’ work and approach while sharing information and skills. Cross-pollination of expertise creates an atmosphere of mutual respect, which in turn points to more opportunities for improving care for clients together.

That’s just what happened in Temiskaming, where interprofessional collaboration from day one allowed for increased and improved maternity care services in the hospital (see page 4).

More and more, midwives are key members of hospital committees working towards lowering c-section rates, as is the case at William Osler Hospital in Brampton (see page 8).

Midwives are also integral members of health care teams working with vulnerable people, such as new immigrants and refugees (see page 10).

Midwives are independent, primary care providers, but we don’t work in isolation. We are an essential part of the health care system and members of maternity care teams in hospitals across the province.

Collaboration is a two-way street – at least two-ways – meaning all the participants are both teaching and learning. When everyone contributes to growth and solutions, the real beneficiaries are women and their babies.
Strong interprofessional collaboration leads to innovative maternity care

For the team working in the birth unit at Temiskaming Hospital, excellent interprofessional collaboration (IPC) is just how they do business.

But to anyone else, the successful IPC relationship the clinicians have forged is a shining example of how teamwork, communication and education can ensure optimal care in the community.

A small, rural centre that sees approximately 300 births a year, Temiskaming Hospital has no obstetricians on staff. It does, however, have a team of family physicians who work closely with the local midwifery practice to bring excellent care during pregnancy and birth to the families living in Temiskaming Shores, Ontario – a community of approximately 10,000.

Midwife Kim Cloutier Holtz began practicing in Temiskaming three years ago, but started laying a foundation with hospital staff long beforehand.

"Before I even had hospital privileges, I sat down with physicians and key people from the hospital to ensure we'd have a good relationship," she says.

The team devised a model for how midwifery care would work in the hospital setting and ensured all players were happy with the arrangement. Cloutier Holtz maintains primary care with nursing support – i.e. nurses will help monitor clients who receive oxytocin drips under Cloutier Holtz's care, as they would for a physician.

Cloutier Holtz says the Ontario Hospital Association's Resource Manual for Sustaining Quality was the key tool she used when working with hospital staff on privileges as well as with local Emergency Medical Services staff when determining home birth transportation protocols.

This sense of teamwork has always been strong in Temiskaming, Cloutier Holtz says.

"There's been a general openness and willingness to learn and grow, on the part of all parties," she says.

Cloutier Holtz attends and takes part in grand rounds, is part of the hospital's MoreOB program and sits on the perinatal committee.

Dr. Stacy Ann Desilets is a family physician who provides obstetrical care in the community and works closely with Cloutier Holtz.

She says that establishing good working relationships at the outset and promoting ongoing education and communication are essential to good interprofessional care.

"Clearly defining the roles of each care provider and providing reassurance that we're not here to take work from one another, but to learn from one another, is key," Desilets says.

Learning is a two-way street for the team. Physicians have attended home births with Cloutier Holtz and take part in education sessions she leads.

Desilets says she has learned a great deal through the collaborative relationship with Cloutier Holtz.
"I think it has improved my care in that I’ve learned techniques, non-medical ways of supporting labouring women through watching Kim and discussing cases and working with her," she says.

The hospital has recently broadened the care options offered to patients by providing the choice of water birth in the hospital setting.

This innovative new step allows the hospital to provide patients with the care they want, with either physician or midwife.

"Kim helped with the education of staff and physicians," says clinical nurse manager Joan Brazeau. "With that collaboration, we have brought that service to the community, the option is now here."

The staff at Temiskaming Hospital believe some of the initiatives from this collaborative model, such as water birth, will result in cost benefits to the hospital and better outcomes for patients and are tracking their data to verify if that is happening.

"Especially with water labour and birth," Desilets says. "Over time (we anticipate) we’ll see less need for other types of analgesia, which would be cost-effective for the hospital and also ideal for reducing risk for mom and baby."

The strong interprofessional relationships at Temiskaming have also allowed the staff to address an issue that often challenges care providers in small communities: what to do when they require time off call. In Temiskaming, patients benefit from seamless care thanks to the mutually beneficial arrangement between the physicians and the local midwife.

Until recently, Cloutier Holtz was a solo midwife. During times when either she or Desilets were away, they would cover each other’s patients.

“They rely on me and I rely on them,” she says of the other care providers. “We really work together to provide the best patient or client care.”

Dr. Pace, pictured here and in the cover photo with the Temiskaming maternity care team, passed away suddenly in a car accident on January 20, 2014. Dr. Pace left an indelible mark on northern health care, as a strong supporter of the Northern Ontario Medical School and the integration of midwifery at Temiskaming Hospital. Midwives who worked alongside Dr. Pace are deeply saddened by his passing and are ever grateful for the ways in which he worked so tirelessly and compassionately on behalf of women and their families.
Midwives and interprofessional collaboration

Interprofessional collaboration ensures the client is kept at the centre of her care. She gets what she needs from the health care system - the right care at the right time from the right provider. Midwives collaborate with health care colleagues regarding individual client care, community and hospital policies, and provincial-level strategy and planning.

We have a plan to transform Ontario's health care system to meet these goals for patients and ensure our system is sustainable for our children and grandchildren.

At the heart of our action plan is a commitment to ensure that patients receive timely access to the most appropriate care in the most appropriate place.

The right care also means care that is provided by the appropriate health-care professional. We have taken steps to expand the scope of practice of a number of health care professionals [including midwives]...so that they are contributing their full potential to the benefit of patients.

Midwives may consult with various specialists while caring for both client and baby, or the midwife may provide all of the primary care needed for both the client and baby, from conception to six weeks postpartum.

Collaboration is an essential precondition for successful interprofessional care. The midwifery model of practice contains explicit expectations outlining the fundamental role of collaboration between midwives, and between midwives and other providers.

In addition, midwives’ practices are underpinned by the primacy of women’s participation in their own care, including the decision about choice of birthplace. Collaboration has been and continues to be a key tenet for Ontario midwives.
Midwives and interprofessional collaboration

Ob/Gyn, family physician, radiologist, geneticist, endocrinologist, psychiatrist/psychologist, paediatrician, RN, registered nurse, NP, nurse practitioner, pharmacist, paramedic, social worker, dietitian, lactation consultant.

The Ontario Hospital Association supports the integration of midwives into the services provided by Ontario hospitals, and recognizes midwifery as a reliable and effective means of providing high-quality maternal and newborn services. The midwifery model of care is collaborative and involves ongoing dialogue and relationships with other members of the maternal-newborn team. It is essential that the various maternity care providers work collaboratively to deliver the best quality of care in every health care setting.

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Interprofessional team tackles c-section rates at William Osler Health System

Cathie Bulstrode, a midwife at Midwifery Care of Peel and Halton Hills, is a member of the new C-Section Optimization Committee at William Osler Health System. The committee is changing attitudes and policies about c-sections, affecting both clients and health care providers.

Bulstrode and fellow midwives Rebecca Johnson and Mariana Tseitlin are collaborating with interprofessional colleagues at William Osler to look at ways to reduce the organization’s c-section rates. Other members of the committee include obstetricians, family physicians and labour and delivery nurses, as well as representatives from anaesthesiology, paediatrics, decision support, staff education and communications.

The committee is co-led by Paula Stewart, a clinical nurse specialist in the Women's and Children's Services Program, and Dr. Nicholas Braithwaite, the Chief of Obstetrics and Gynaecology.

Stewart has special insight into the expertise of the midwives. She’s a British-trained midwife who attended home and hospital births and taught midwifery in the UK before coming to Canada and beginning a nursing career focused on labour and delivery.

This summer Stewart learned about the AOM’s client resource Thinking about VBAC: Deciding what’s right for me, which is based on the AOM’s clinical practice guideline Vaginal Birth after Previous Low-Segment Caesarean Section, from Johnson. Stewart contacted the AOM to get more information about the document and used the information in it as the basis for William Osler's new client fact sheet on VBAC.

Stewart says one of the committee’s initiatives, having nurses provide continuous intrapartum support for women in labour, is inspired by midwifery care. The committee also incorporated a number of statements from the AOM’s clinical practice guidelines that are related to encouraging spontaneous second stage pushing, supporting women with alternate pain management options, using intermittent auscultation for fetal surveillance in low risk women and encouraging women to walk around and change positions during labour.

“This is about nurses being present with patients as much as possible; actively supporting them in their decision-making during labour and creating a calm and intimate birth environment. Our midwifery colleagues do this amazingly well,” says Stewart.

In addition to contacting the AOM, Stewart collaborated with Markham Stouffville Hospital, which has succeeded in bringing down its c-section rate and increasing the percentage of VBACs. (See Winter 2013 issue of Ontario Midwife.) Stewart says the committee analyzed strategies used at Markham Stouffville to determine which ones would be appropriate for the patient population and service providers at William Osler.

Reducing the c-section rates at the health system’s two sites, Brampton Civic Hospital and Etobicoke General Hospital, is a corporate improvement initiative. The committee was formed in July to support this organizational objective.

According to Dr. Braithwaite, the corporation’s c-section rates are currently 32%. “The goal is to reduce them by 10% over the next two years. That would bring us more in line with provincial and national averages,” he says.

Each year, approximately 5,100 babies are born at William Osler’s Brampton Civic Hospital and about 2,400 are born at Etobicoke General Hospital.

Braithwaite says there are numerous benefits to having an interprofessional committee look at an issue like c-section rates. Everyone brings to the table a perspective which adds to the quality of the decision-making. It also really improves the understanding of different perspectives on managing a particular issue and engenders respect for different approaches.

Dr. Nicholas Braithwaite, Chief of Obstetrics and Gynaecology
“Everyone brings to the table a perspective which adds to the quality of the decision-making. It also really improves the understanding of different perspectives on managing a particular issue and engenders respect for different approaches. We’ve had some very good and frank discussions.”

The midwives are an integral part of the committee, says Braithwaite, bringing expertise on obstetrical care and labour management.

“Obstetricians have a perspective that may be more slanted towards complications, as opposed to midwifery which is more slanted toward low risk, normal situations. And in the discussions we have on balancing those perspectives, midwifery is critical to that process. I value their input greatly.”

Cathie Bulstrode says she has an equal voice on the committee and feels well-respected by the other members. “They’ve seen a lot of our normal, straightforward births so that builds relationships and it seems to build a respect and a trust,” she says.

For example, the committee responded enthusiastically when Bulstrode suggested that testimonials from women who’ve had successful VBACs be added to information boards in the health centre’s labour and delivery and clinic areas that show the organization’s quarterly c-section and VBAC data. Two of her clients wrote testimonials and now the clinical data is balanced with information about women’s experiences told in their own words.

Bulstrode recently admitted a home birth client experiencing slow second stage labour to Brampton Civic Hospital. The consulting obstetrician recommended a c-section. Because of the committee’s work, Bulstrode and the physician explained the options to the client. She continued to labour for a few more hours and think about what she wanted to do.

“I don’t know if [the physician] would have done that if awareness hadn’t been raised that we are trying to get the c-section rate down. The client ended up with a caesarian section – and it was the right thing to do – but the woman felt like she had an opportunity to be heard and to make a choice. And we all knew that the c-section was absolutely necessary,” says Bulstrode.

Stewart says that in addition to giving health care providers the resources they need to reduce c-sections, the committee’s initiatives will enable patients to be active participants in their health care. “It’s all about providing patients with evidence-based information and encouraging and supporting them as they make decisions based on the right information.”

Braithwaite agrees. He says that while he’s confident that the committee’s initiatives will help the organization reduce its c-section rate, “the real gem will be the impact on the quality of care and on patient awareness and patient involvement in decisions.”

Committee members include (left to right): Lindsay Hogeboom, Clinical Nurse Specialist (CNS) for the Women’s and Children’s Program; Dr. Caroline Collins, Family Physician and Lead Physician for Primary Care Obstetrics; Antonia Whittaker, Patient Care Manager for the Maternal Newborn Program; Bridget Mitchell, Clinical Nurse Educator for the Maternal Newborn Program; Daphna Margolis, Clinical Administrative Assistant to Dr. Nicholas Braithwaite, Corporate Chief of Obstetrics & Gynaecology; Karen Heyduk, registered nurse in Labour and Delivery Unit; Cathie Bulstrode, registered midwife; Paula Stewart, CNS for Maternal Newborn Program; Dr. Quynh Le, Obstetrician; Dr. Nicholas Braithwaite, Corporate Chief of Obstetrics & Gynaecology; Laurence Wolfson, former Director of Women’s and Children’s Programs and Dr. Karen Gronau, Obstetrician.
As a partnership of seven Toronto community health centres (CHC) run by Access Alliance multicultural health services, the west end Non-insured Walk-in Clinic (NIWIC) was established in 2012 to fulfill an unmet need: to provide care for those without health coverage whether due to precarious status, failed refugee claims or the three-month OHIP wait.

But not long after opening, it quickly became clear to nurse clinical coordinator Sideeka Narayan there was another group of people whose needs the clinic still could not meet – pregnant women without status.

“We were not set up to provide ongoing, routine prenatal care,” Narayan said. However, knowing how essential prenatal care is, particularly to this vulnerable population, Narayan was looking for a solution.

Fortunately, she knew where to start. Narayan had developed a close working relationship with midwife Manavi Handa of West End Midwives through their work at Access Alliance and together the two set out to solve this unmet need.

In the summer of 2013, Handa began volunteering every Monday at the clinic offering prenatal assessments, but found the enormity of the situation required a more coordinated effort.

“I soon realized I wasn’t able to be the only midwife volunteer and thought this would be a great opportunity for other midwives to build similar CHC relationships,” she says.

Handa approached seven midwifery clinics that service the west end of Toronto and quickly had everyone on board – practices have agreed, when possible, to prioritize the clients referred from the New Immigrant Women’s Clinic.

She also reached out to Toronto midwives looking for others to rotate the “Midwife Monday” volunteer role. Handa was overwhelmed by the response and was able to recruit more than a dozen midwives who each take turns coming in on Monday nights.

Midwifery-CHC collaborations protect vulnerable populations

“If this community clinic didn’t exist, where would these women be going? We’re providing care that wasn’t there before, so we’re improving birth outcomes.”

Sideeka Narayan, RN

Intentional partnership helps clients

Pairing with Community Health Centres (CHC) to provide collaborative care is not new to midwifery, nor is it only reactive to the recent refugee health care cuts.

The Midwife Clinic in Mississauga has had a fruitful partnership with the LAMP Community Health Centre dating back to when the practice was first established in 2011. The practice first shared clinic space with the CHC and is now housed next to the CHC.

The practice has a focus on providing care to new immigrants and refugees, and saves 75% of its spaces for these clients. The close relationship with the CHC means physicians can direct clients to the practice for care and the midwives can easily refer clients to family doctors right next door.

“The relationship started off with intentions of a partnership and not just a marriage of convenience,” says midwife Karen Hayoe. “LAMP works a lot with new immigrant women and families…if one of the nurse practitioners came to us and said they had a woman with no OHIP, we make every effort to accommodate their clients.”
The midwives perform an initial prenatal assessment as well as brief health and obstetrical history to determine if clients are high or low risk. Those who are low risk get referred to one of the seven midwifery practices that try to prioritize these clients. Those who are high risk are referred to an OB through the NIWIC.

The NIWIC was established in March 2012. “Midwife Mondays” began in June 2013. Since that time, the midwives have seen more than 30 clients – 75% of which have gone into midwifery care at one of the partnering midwifery practices.

With so many living in the greater Toronto area without status, it’s a model that is already seeing results.

“Manavi Handa and Sideeka Narayan collaborated to create a prenatal care service for uninsured pregnant women.

“If this community clinic didn’t exist, where would these women be going?” asks Narayan. “We’re providing care that wasn’t there before, so we’re improving birth outcomes.”

Through the new clinic, Handa also recently saw a client who had lost her IFH coverage following government cuts.

“Her pregnancy was quite complicated…when I saw her she was more than 36 weeks pregnant and had no prenatal care at all,” Handa says. Because of complications in the pregnancy, the client needed to see an OB and deliver via c-section. Thanks to the new clinic and collaborations established because of it, Handa was able to get the client in to see an OB and the Community Health Centre covered the costs of the surgery.

The interprofessional work at the clinic also ensures clients receive optimal care. When clients require tests for conditions outside of maternity care, such as thyroid or asthma, nurses can order tests and requisition results.

Handa and Narayan believe this model is not only beneficial but easily replicated. They are hoping to at conduct research and disseminate findings on how this model can be implemented in different jurisdictions.

This kind of valuable work, and that provided by the midwives volunteering with the NIWIC, is possible thanks to midwives’ dedication Handa says.

“What has made this so successful is the number of midwives who have volunteered.”

Manavi Handa, RM
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