Association of Ontario Midwives
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Association of Ontario Midwives Emergency Health Services Modernization Consultation Submission

The Association of Ontario Midwives supports the government's initiative to modernize emergency health services in Ontario. While midwives manage labour and birth mostly in hospital, they also provide care at home and in the community in clinics and birth centres. Midwives rely on being able to access EHS when a pregnant person needs to be transferred from home or community into hospital to manage an emergency. Midwives providing care in rural, remote and Far North communities have particular needs when it comes to EHS in order to ensure safety for Ontarians.

Midwives are the only health care providers funded by Ontario to manage labour and birth across three different settings – in the home of a client, in a hospital where they hold admitting and discharging privileges and in birth centres (there are three birth centres in Ontario – Ottawa, Toronto and Six Nations). Last year, midwives provided care to over 25 000 families, and while 83% chose to have their babies in hospital, 17% chose to have their babies either at home or in a birth centre.[1] Maintaining the ability of Ontarians to access home birth with a midwife not only has many benefits for families but it also supports efforts to transform health and end hallway medicine by keeping care in the community and out of hospital.[2] Midwives reported in key informant interviews that while EHS is integral to supporting the ability of Ontario to provide care in the community with a midwife, that there are issues with communication and efficient call management which need to be modernized.

In addition, midwives report specific concerns with the role of EHS in remote and Northern communities. Many of these communities are working to end a practice of routine medical evacuation for birth and are instead attempting to move towards keeping care in the community, including the management of birth, with a midwife. Routine evacuation for birth largely impacts Indigenous people, and has been referred to as the "residential schools of medicine". [3] The Society of Obstetricians and Gynecologists in Canada (SOGC) reaffirmed in 2017 their statement on *Returning Birth to Aboriginal, Rural and Remote Communities* providing evidence that returning low-risk birth to Indigenous communities is an important pathway of reconciliation, and linked local

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[1] BORN (Better Outcomes Registry Network) April 1, 2017 - March 31, 2018 data.
[2] Association of Ontario Midwives. Quadruple aim and midwifery care. Ontariomidwives.ca [Internet]; 2019. Available from: https://www.ontariomidwives.ca/sites/default/files/2019-08/Quadruple%20Aim%20Final%20PDF.pdf
[3] Payne, E. The residential schools of medicine. Ottawa Citizen [Internet]. November 26, 2010. Available here: http://www.ottawacitizen.com/health/residential+schools+medicine/3889424/story.html

maternity care with cultural safety and community health.[4] Keeping birth in remote and Northern communities also requires modernization to EHS and Ornge Air in particular.

The Association of Ontario Midwives recommends:

1.0 Modernizing Ambulance Communication Centres – Communication and Co-ordination

Context:

Managing labour at home is safe and one of the components needed to ensure safety is EHS.[5] In this setting, a midwife is the most responsible provider (MRP), which means they hold overall responsibility of leading and coordinating the delivery and organization of a client's care at a specific moment.[6] Midwives are highly skilled and are experts in managing obstetrical care, including emergencies, in out-of-hospital settings. Midwives are the only primary care providers who provide client care in home, hospital an community, including during transitions between these settings.[7]

1.1 Challenge: EHS call management does not account for a primary care provider initiating a 911 call

A 911 call between a midwife and Ambulance Communications Centre is usually inefficient because the generic script for triaging labour and delivery calls is intended for a member of the general public and not for a healthcare professional. As highlighted above, in out-of-hospital (pre-hospital) settings the midwife is the most responsible provider (MRP). The challenge of the generic script in this context, is that it does not account for the healthcare provider already assessing and expertly managing care. Therefore midwives report most of the questions are not relevant. Because a midwife must answer questions that are not clinically applicable in a generic triage script, the

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[4] Society of Obstetricians and Gynaecologists of Canada. SOGC policy statement: returning birth to aboriginal, rural, and remote communities. J Obstet Gynaecol Can, 2010; 39:12, e1186-1188.
[5] Expert Advisory Panel on Choice of Birthplace. Association of Ontario Midwives. Guideline on discussing choice of birthplace with clients. 2016.
[6] College of Midwives of Ontario. College of Midwives of Ontario [Internet]. Toronto. Most responsible provider. Available from: http://www.cmo.on.ca/glossary/most-responsible-provider/
[7] Association of Ontario Midwives. Quadruple aim and midwifery care. Ontariomidwives.ca [Internet]; 2019. Available from: https://www.ontariomidwives.ca/sites/default/files/2019-08/Quadruple%20Aim%20Final%20PDF.pdf

midwife has to spend more time than necessary on the call which interrupts the delivery of client care and preparing for ambulance arrival during an emergency. In our key informant interviews with midwives across the province, inefficient call management because of a generic script was a key problem in need of modernization to reflect the role of midwives in Ontario.

Solution: Create a Triage Script for Midwife-Led EHS Calls

Develop an Ambulance Communications Centre standardized script for EHS calls for midwife-led calls. Ideally the revision process would include input from midwives to ensure the call management process is efficient and effective for both midwives and Ambulance Communications Centre personnel resulting in increased integration with primary care providers and better patient outcomes and experience because unnecessary delays in care are avoided.

1:2 Challenge: EHS call management does not account for a primary care provider recommendations

I called EHS to arrange transport for a newborn baby in distress. Prior to the call, I consulted with the pediatrician at a Level II hospital who was ready to receive the patient. During the 911 call, despite my assessment and recommendation, dispatch personnel disregarded the coordinated care plan and instead directed the ambulance to take the infant to the closest hospital, a Level I hospital that did not have a pediatrician on-call. Once arriving at the Level I hospital, the infant was sent in a different ambulance to the Level II hospital so they could receive the necessary care from the appropriate provider. Both the pediatrician and I were deeply concerned about the impact this delay of care could have on the baby's outcome. These frustrations were compounded by the fact that we were in a rural area of Ontario, where travel distances are not inconsequential.

– Ontario midwife

Unfortunately this narrative is not uncommon. While some Ambulance Call Centre personnel are receptive to healthcare provider clinical recommendations in the transfer plan, midwives report this is varied and inconsistent across the province.

The Solution: Integrate MRP expertise in transport plan

Integrate clinical recommendations from the most responsible provider for transport planning and ensure the process is transparent to healthcare providers. Where appropriate connect a MRP to the Base Hospital physician to consult.

1.3 Challenge: Dispatch script does not account for midwives

Midwives working in remote and Far North communities who regularly use Ornge Air, report that the dispatch script requires that the caller identify the "transferring physician". This requirement overlooks that the MRP may be a midwife or a nurse practitioner. How this issue is managed is inconsistent and seems to depend on the individual Ornge Air dispatch personnel. Some accept the midwife as the "transferring physician", while others insist on a physician being named and thus delays in care are caused while dispatch and the midwife debate, and even more time is wasted if the midwife is forced to locate a physician, even if that means identifying a physician located hundreds of kilometers away, who is willing to be the "transferring physician".

The Solution: Dispatch script can ask for primary care provider, instead of physician

To ensure efficient and effective emergency call management, revise the dispatch script for Ornge Air to reflect that the primary care provider transferring the client could also be a midwife or a nurse practitioner.

2.0 Health Equity Across Regions and Communities

Context:

The Society of Obstetricians and Gynecologists of Canada's clinical guideline *Rural Maternity Care* states that clinical outcomes are better when clients do not have to travel far from their communities and that innovative interprofessional models should be implemented to ensure high quality and integrated care for clients in rural and remote areas.[8] The National Council of Aboriginal Midwives (NACM) and the Association of Ontario Midwives (AOM) are working towards the restoration and renewal of indigenous midwifery and the return of birth services in remote and Far North communities. Planned routine evacuation for birth from Northern communities to large southern centres has a profoundly destructive impact on Indigenous communities and leads to poor birth outcomes for Indigenous families.[9] Giving birth in community is safe and evidence demonstrates that communities served by midwives with careful risk

[8] Society of Obstetricians and Gynaecologists of Canada. No. 282-rural maternity care. J Obstet Gynaecol Ca 2017; 39(12): e 558-565.

[9] National Council of Aboriginal Midwives. Position statement on evacuation for birth. National Council of Aboriginal Midwives [Internet]. Available from: https://indigenousmidwifery.ca/wp-content/uploads/2019/05/PS_BirthEvac.pdf

screening have better health outcomes than those communities that are forced to have a routine evacuation policy. However, some pregnant people will have a medical issue that cannot be attended in community and they will need to access care away from home.[10] Emergency health services has a pivotal role in returning birthing services to remote communities. People in remote communities need reliable, well-resourced and efficient emergency health services. This allows primary care to be delivered in-community, knowing that emergency transport can be accessed if needed.

2.1 Challenges: Delays in arranging emergency transport

Midwives working in remote and Far North communities report detrimental delays in care. Delays are caused by the need to coordinate care with multiple levels of emergency health services. This cause delays in care and depletion of local healthcare resources.

> The closest tertiary hospital from Kenora is 200 km away in Winnipeg, Manitoba. When I need to arrange emergency transport to Winnipeg I need to separately call municipally-managed land ambulance services and provincially-managed Ornge Air. Both calls require that I answer all the required questions and provide a medical assessment, then municipal and provincial EHS negotiate between themselves as to who will lead the transport. While the decision is being made, one or both levels of EHS may call me back for more information or an update on my patient's condition. This lengthy period of discussions impacts client care because it delays the transport and consumes the resources of the midwife or nurse who is consulting separately with two different levels of EHS. Sometimes the delays are so significant that a family will choose to drive themselves the 2.5 hours to Winnipeg without having medical care on-route.
>
> – Ontario midwife

Solution: Centralize dispatch for provincial and municipal EHS

Centralize and streamline dispatch for all EHS services (land ambulance, air ambulance and CritiCall) so that there is one pathway for all calls and decision-making. Therefore the healthcare provider only calls one number to coordinate the needed emergency transport.

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[10] Ibid

2.2 Challenge: Duplication of efforts

In jurisdictions where healthcare providers regularly coordinate transfer of care with a multitude of partners – Ornge Air, CritiCall, or a specialist at a receiving tertiary hospital - all parties involved require individual and ongoing patient assessment updates that are communicated by telephone until the client is in the care of EHS. This causes duplication of healthcare provider efforts and disruption of clinical care, which is even more acute in remote communities that have severely limited healthcare provider resources.

Solution: Integrated EMR

An integrated EMR between all the EHS service providers and hospitals would facilitate the timely and confidential sharing of relevant clinical assessment information. This could prevent duplication of services, disruption of clinical care and lead to increased efficiency.

2.3 Challenge: Disruption of care

Remote and far-north communities often have established corridors of care with interprofessional relationships and supports already in place. Midwives working in northern Indigenous communities report that these established consulting relationships are at times disregarded in favour of the quickest transport time. And while timely transport times are a priority, it needs to be balanced with the efficiencies gained from existing partnerships between hospitals and care providers and the improved patient and family experience.

Attawapiskat and Kingston have a collaborative partnership between OBs and midwives who regularly coordinate care and consult throughout a client's pregnancy. Furthermore Ininew Patient Services are located in Kingston, and they provide culturally safe and culturally relevant case management supports for Weekneebayko patients and families, including coordination of transportation home. CriticCall will often override this partnership and route Attawapiskat clients to Sudbury because the trip is ten minutes faster, but there are no existing coordination pathways, OB-midwife shared care partnerships for a client with a high-risk pregnancy or the same culturally safe services for indigenous clients.

– Ontario midwife

Solution: Provider and community-driven care pathways

Remote and Far North communities need to be able to self-determine the unique EHS solutions that meet their community needs. Mitigating risk is not solely an issue of quick transport, though that is of vital importance. Modernizing EHS in northern communities requires that decisions for where to transport people includes the needs and recommendations of communities and the providers in those communities, including midwives.

3.1 Innovation in Interprofessional Collaboration

The Association of Ontario Midwives, in partnership with the Ontario Base Hospital Group (OBHG), developed the *Paramedic Emergency Skills Program (PESP): Managing Birth Out-of-Hospital* in 2017 to reflect the evolving scope of paramedic practice, including the Emergency Childbirth Medical Directive and Advanced Life Support patient care standards. The PESP is a full-day, in-person event with simulated emergency childbirth scenarios providing paramedics with the knowledge, evidence-based practice and hands-on skills to manage out-of-hospital births with confidence and competence.

This successful and innovative program could be scaled-up and tailored to meet the specific needs of paramedics working in rural and remote areas and implemented as a mandatory requirement of paramedic college education. This approach to inter-professional collaboration equips paramedics to be skilled and confident when responding to obstetrical calls, whether or not a midwife is on scene.

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