Association of Ontario Midwives
*Delivering what matters.*

July 15, 2020

Dr. David Price, Ministry of Health of Ontario Co-Chair
Dr. Nadia Alam, Ontario Medical Association Co-Chair
Primary Care Working Group (PCWG)

**Re: submission to OMA-MOH Primary Care Working Group (PCWG)**

The Association of Ontario Midwives (AOM) welcomes the opportunity to provide feedback and recommendations to the Primary Care Working Group (PCWG).

## Access and Quality Issues

The Ministry of Health of Ontario and the Ontario Medical Association's commitment to working collaboratively with other health care practitioners while putting clients' interests first aligns perfectly with our association's evidence-based, cost-effective recommendations for Ontario's health sector. This submission will cover access and quality issues within our primary care sector - midwifery - and provide recommendations to improve these issues. More specifically, we will discuss the issue of midwifery referrals to specialists as well as the importance of refining our maternity care sector so that it is sensitive to the appropriate use of primary care resources and client needs and leveraging opportunities for primary care collaboration.

## 1. OHIP Billing Codes for Midwifery-Requested Assessments

### Overview

As primary care providers and specialists in low risk pregnancy, birth, postpartum and newborn care, midwives sometimes require referrals to specialist physicians to meet the needs of their clients. While OHIP billing codes exist for midwives to directly refer their clients to a small number of generalist and specialist physicians, billing codes do not exist for direct referrals for a number of consultations that may arise in the course of care. There are no OHIP billing codes for midwives referring directly to endocrinology for gestational diabetes, or to psychiatry for postpartum depression. In these common scenarios, clients must be referred to family physicians or obstetricians who can then request a specialist consultation for midwifery clients. In many cases, these physicians have not previously been involved in the care of these clients, whereas the midwife, as primary care provider, knows the clinical details and relevant

history. The most common specialist referrals for midwifery clients (and their babies) are to psychiatry, endocrinology, hematology, pediatrics (non-urgent), and pediatric cardiology.

The existing OHIP billing codes for midwives to request direct specialist consultation are:

- Anesthesia assessments (A816/C816)
- Assessments from family physician or obstetrician (A813/C813)
- Special assessment for emergencies from pediatrician, family physician, or obstetrician (A815/C815)
- Genetic assessments (A800/C800, A801/C801, A802/C802, K224)

This system of direct physician referrals by midwives has been working well for many years and provides validation for expanding the list to other midwifery-requested assessments.

## Access to Timely Care

One of the biggest issues that a lack of direct midwifery-requested referrals creates is a delay in timely access to care. Timeliness of perinatal care is vital for the health of pregnant and postpartum individuals and their babies. The obstacle of requiring midwifery clients to see a family physician or an obstetrician before being referred to the appropriate specialist can undermine timely and efficient client care. The problem worsens when clients do not have a family physician and are further delayed in accessing the needed referral while experiencing a condition that requires immediate assessment. This lack of timely access to care can adversely and directly impact client health.

## Reduced Risk of Errors

The practice of first referring clients to an intermediary provider results in unnecessary steps in the consultation process and has the potential to increase medical errors due to a loss of information from these additional steps. First, the midwife must relay the relevant information to family physician or obstetrician who may not have any previous knowledge of the client's history. Once the specialist consultation has taken place, the report and recommendations for care typically go to the family doctor or obstetrician. To obtain specialist consultation reports from a FP and/or OB often requires midwives to chase after them. Having direct access to this information from specialists reduces the time it takes to obtain such information and improve access to timely care for clients. This important change also has the benefit of saving clients from having to explain their situation to additional providers more times than necessary.

Changes to how referrals are made can support the OMA's and MOH's efforts to reduce unnecessary tests/procedures. Direct referrals to specialists from midwives can eliminate the need for an intermediate consult, thereby reducing duplication of services, and directly result in cost savings that can be diverted to other services. In 2019, the Appropriateness Working

Group[1] developed 11 recommendations regarding unnecessary tests/procedures based on best evidence practices. One recommendation was to improve access to primary and specialty care by simplifying referrals to specialists in order to make it easier for a patient to see a specialist for the same problem within a two-year period without needing to see their primary care provider first. Efforts like this contribute to a more efficient health care system through a reduction of unnecessary visits for clients. These benefits can extend to midwifery clients with the expansion of direct midwifery-requested specialist referrals.

## Better inter-professional relations

A lack of OHIP fee codes for midwifery-requested referrals can also cause confusion within interdisciplinary teams, whereby specialists wonder why midwives cannot directly refer despite being the patient's primary care provider. This can compromise the understanding of midwifery scope of practice and create negative perceptions of the status of midwives as primary health care providers. These perceptions can undermine the inter-professional integration efforts of midwives at the hospital and health system level.

Furthermore, in situations where a telephone consultation or an e-consultation would be appropriate – such as during a pandemic – midwives are denied access to this service because physicians cannot get paid for such consultations with midwives. There is no billing code available for midwives' e-referrals, therefore physicians can and almost always do refuse these types of consultations. This impacts not only client care but also inter-professional relations between midwives and physicians and impedes collaborative care. (Codes K738 and K739 are only available for physician to physician e-consultation and nurse practitioner to physician e-consultation.)

## Recommendation:

## Additional fee codes

Under section A8 of the OHIP Schedule of Benefits, we propose that midwife-requested assessments for the following specialities be added with the corresponding fees[2]:

1. Midwife-Requested Psychiatry Assessment (A195 - $199.40)
2. Midwife-Requested Endocrinology Assessment (A155 - $157.00)
3. Midwife-Requested Pediatric (non-urgent) Assessment (A265 - $167.00)

[1] https://news.ontario.ca/mohltc/en/2019/08/appropriateness-working-group-recommendations.html

[2] Fee codes will be new for midwife-requested assessments but corresponding fees will be the same as existing consultation fees.

4. Midwife-Requested Pediatric Cardiology Assessment[3]
5. Midwife-Requested Hematology Assessment (A615 - $157.00)
6. Midwife-Requested Telephone Assessment (K731 - $40.45 and K735 - $40.45)
7. Midwife-Requested E-Assessment (K739 - $20.50)

Delivering on this recommendation will improve access to care for midwifery clients while meeting the objectives of the Quadruple Aim:

- **Reduces Costs:** reduces duplication of services by eliminating the need for midwives to refer clients to family physicians or obstetricians before they are referred to a specialist, thereby eliminating the OHIP visit fee charged by the family physician/OB and subsequent referral fees
- **Improves Work-Life of Providers:** fosters improved inter-professional relations between midwives and specialist physicians, improving collaborative care
- **Improved Patient and Caregiver Experience:** eliminates an unnecessary doctor's office visit for a pregnant person, post-partum parent, or newborn
- **Better Outcomes:** provides timely access to care, and eliminates unnecessary exposure of vulnerable pregnant people and newborns to illness (e.g. influenza, COVD-19, and other respiratory viruses) in family physician offices

Note: Expansion of existing OHIP billing codes for the aforementioned services is much easier than creating new billing codes. This way, the fee amounts for specialists would remain the same as they are for family physicians and nurse practitioners who refer patients. If new billing codes were added specifically for midwives, they have the potential to invite scrutiny if the new fee amounts are lower than those for referring FPs and NPs. If midwives are added to existing fee codes, specialists will not be penalized for seeing midwifery clients over FP and NP clients, thereby mitigating potential inter-professional conflict.

A further enhancement to the OHIP Schedule of Benefits for midwifery clients is the creation of a repeat assessment code for midwife-requested assessments A813/C813 and A815/C15. OHIP billing codes A813 and A815 (midwifery-requested assessments) are available for OB consultations but the fee schedule limits their use to one per patient per pregnancy. This is problematic when a client requires a second consultation from an OB for the same pregnancy.

For example, if a midwife requests an OB consultation for oxytocin orders in a hospital that requires this consultation for labour induction or augmentation and then consults 7 hours later for an abnormal fetal heart rate, the OB cannot be paid for the second consultation because there is no applicable billing code. Under the current system, the obstetrician may be incentivized to unnecessarily transfer care when there is no mechanism to bill for a second consultation for the

[3] Pediatric Cardiology is a subspecialty of pediatrics so it is unclear which code would be most appropriate for an assessment requested by a midwife. (Only specialties have clearly indicated codes, subspecialties are not included under 'consultations and visits' in Schedule of Benefits.)

same pregnancy (patient). A midwife-requested repeat assessment code can appropriately compensate OBs for their work while discouraging unnecessary transfers care for greater billing opportunities. This approach supports the midwives' ability to provide primary care to their scope of practice while fostering and compensating appropriate inter-professional collaboration.

Thus, it is recommended that a repeat assessment code be created for midwife-requested assessments A813/C813 and A815/C815. Code A206 is a repeat consultation code for obstetrics and gynecology under general listings (A91 in Schedule of Benefits). The corresponding fee is $54.10. A new Midwife-Requested Repeat Assessment code with a fee of $54.10 is proposed to resolve this issue.

## 2. Client Access to Midwifery Services

### Overview

Another area for improvement in primary care is client access to appropriate maternity services. Midwives are publicly funded primary care providers and experts in low-risk pregnancies. While low-risk pregnancies make up the bulk of pregnant clients in Ontario, only 17%[4] are cared for by midwives. The rest are cared for by family physicians or referred to OB specialists, often by family physicians. Some family physicians lack awareness or may have biased or incorrect information about midwifery. Consequently, some family physicians may not provide information about midwifery to their patients who would be eligible for midwifery care.

Every pregnant Ontarian has the right to make an informed decision about who their primary obstetrical healthcare provider will be; some patients may not have complete information that includes midwifery to make this informed choice. This can lead to a disproportionate amount of healthy low-risk pregnancies being cared for by high-risk specialists. Increasing family physicians' awareness of and knowledge about the midwifery model of care and scope of practice can assist in matching pregnant patients with the most appropriate health care provider.

### Benefits of Midwifery Care for Family Physician Clients

As primary care providers, midwives provide high quality, primary health care for low-risk pregnancies. Some family physicians may be unaware of the midwifery services in their communities or have misconceptions about the scope of practice and safety of midwifery care. Ensuring all family physicians have access to information about the midwifery services in their area and setting a standard by which all FPs are expected to inform their low-risk patients about

[4] BORN Ontario. Midwifery Care Profile – Utilization of Services 2016-2017. 2019 May.

the option of midwifery care will increase patient satisfaction, access to perinatal services and contribute to healthy outcomes.

Ontario midwives are specialists in providing around-the-clock, on-call care for clients throughout normal pregnancy, birth and the first six weeks after birth. Midwives follow the client between home, community and hospital settings, depending on the needs of that client. For clients that require specialist consultations, midwives are able to refer them (see above for recommendations to improve this referral system) or transfer their care as needed.

In 2019, over 29,000 families received care from a midwife. Over 240,000 families have received midwifery care in the past 15 years.[5] With a proven safety record, midwives are experts at providing high quality, evidence-based primary care to clients and their newborns in hospital, home, and birth centers. They provide care that Ontario families deeply value. Moreover, midwifery clients have lower rates of intervention and shorter hospital stays.[6] By offering birth at home, clinic or at birth centers, as well as providing successful vaginal birth after C-sections, Ontario midwives effectively reduce hospital stays and further improve access to care for Ontarians by freeing up beds and hospital resources for those who need it most.

Midwives and family physicians can work together to provide comprehensive care throughout the life cycle. Midwives provide a seamless transition between hospital and home, and have great success in coordinating and delivering care for families in Ontario in both acute care and community settings. They can provide care from the very beginning of pregnancy and refer clients and their newborns back to family physicians upon discharge from midwifery care at 6 weeks post-partum. There are currently over 1000 registered and Aboriginal/Indigenous midwives providing care in over 90 communities across Ontario.

## Reduced admissions to hospital for birth

Birth is the number one reason for hospital admission in Ontario.[7] Midwives offer their clients alternative choices in birth place, including home birth. The provision of safe home birth by midwives has been a major success story for Ontario health care, with estimated cost-savings of approximately $2,338[8] per home birth. At a rate of approximately 20%[9] for out-of-hospital births, midwives save our health care system over $11 million every year.

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[5] Idem.

[6] Idem.

[7] Hospital Morbidity Database and Ontario Mental Health Reporting System, 2016–2017, Canadian Institute for Health Information. Retrieved from: https://www.cihi.ca/sites/default/files/document/hospch-hosp-2016-2017-snapshot_en.pdf

[8] Janssen PA, Mitton C, Aghajanian J. Costs of planned home vs. Hospital birth in British Columbia attended by registered midwives and physicians. PLoS One. 2015. Retrieved from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0133524

[9] BORN Ontario. Midwifery Care Profile – Utilization of Services 2016-2017. 2019 May.

Birth Centres are also a major success story in Ontario; with 3 freestanding birth centres fully operational in the province, there is a third option for midwifery clients in Toronto, Ottawa and Six Nations of the Grand River while successfully diverting those clients from hospital.

## Shorter length of stay, lower costly interventions, high rates of exclusive breastfeeding

Midwifery is associated with shorter hospital length of stay and lower costly interventions (e.g. C-section – the most common in-patient surgery) than the provincial average. Midwifery clients in Ontario had a 12% lower C-section rate and a 38% lower epidural rate than the provincial average in 2017.[10] The average length of stay for hospital births attended by midwives is approximately 1.8 days,[11] while the provincial average is 2.3 days.[12] This difference will likely be further enhanced now that midwives have secured funding for transcutaneous bilimetres. Bilimeters allow midwives to provide appropriate newborn screening in the community setting without the need for a 24-hour stay in hospital. Many midwifery clients are discharged home from hospital in less than 6 hours. After discharge from hospital, midwives provide on-call, community-based postpartum care.

Midwives have higher rates of successful vaginal birth after C-sections (VBAC) which also shortens hospital stays, reduces costly interventions (C-section), and contributes to exemplary client experience. In 2017, 52% of midwifery clients that were eligible for VBAC had a successful VBAC, compared to 19% of non-midwifery clients.[13]

Infants in midwifery care have higher rates of exclusive breastfeeding at six-weeks. Midwives encourage early initiation of breastfeeding, and home visiting in the first week of life addresses common breastfeeding challenges to support perseverance and success. Exclusive breastfeeding has significant long-term health impacts including a reduction in rates of obesity and allergies. (needs stats and references)

## Excellent client experience

Midwifery clients report high rates of satisfaction.[14] Reasons for this include 30-60 minute visits, 24/7 availability, continuity of carer, and a client-centred, informed choice model of care.

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[10] Idem.
[11] Idem.
[12] Hospital Morbidity Database and Ontario Mental Health Reporting System, 2016–2017, Canadian Institute for Health Information. Retrieved from: https://secure.cihi.ca/free_products/hospch-hosp-2016-2017-snapshot_en.pdf
[13] BORN Ontario. Midwifery Care Profile – Utilization of Services 2016-2017. 2019 May.
[14] Public Health Agency of Canada. What Mothers Say: The Canadian Maternity Experiences Survey. Ottawa: 2009. P. 225

## Diversion from ED and L&D

Twenty-four hour on-call availability from the prenatal period all the way until 6 weeks postpartum diverts unnecessary visits to Labour and Delivery and Emergency Departments while clients are under midwifery care. Midwives remain on-call 24/7 and are able to provide high-quality care outside of hospitals and in the community. Continuity of care with known midwives reduces handovers between caregivers which reduces replication of services and improves safety. [15] [16] [17]

The AOM recommends working together with the OMA to provide opportunities for increased awareness about midwifery care for family physicians, leading to increased referrals to midwifery care by family physicians.

## Collaborative and integrated care

Ontario has increased opportunities for physician and midwife collaboration. Since 2017, alternate funding models are available through the Ministry of Health's Ontario Midwifery Program's Expanded Midwifery Care Models to facilitate midwife and physician collaboration. This funding is intended to expand the models of care in which midwives can contribute to improved perinatal and newborn outcomes and to increase access to care.

Current models such as MATCH in Toronto and Crown Point Family Health Centre in Hamilton exemplify positive primary-care collaboration between midwives, physicians and allied providers. The addition of midwives to Community Health Centres and Family Health Teams can increase access to primary sexual and reproductive care such as Pap testing, IUD insertion and medical abortion and decrease wait-times for these vital services. These successful models provide opportunities for midwives and family doctors to innovate together to serve community need.

The Association of Ontario Midwives recommends working with the Ontario Medical Association to promote successful collaborative care in Expanded Midwifery Care Models.

[15] Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5

[16] Greenberg CC, Studdert DM, Lipsitz ST, Rogers SO, Zinner MJ, Gawande AA. Patterns of communication breakdowns resulting in injury to surgical patients. J Am Coll Surg 2007;1(10):533-40; Patterson ES, Roth EM, Woods DD, et al. Handoff strategies in settings with high consequences for failure: lessons for health care operations. Int J Qual Health Care 2004;16:125-132.

[17] Glauser J. Handoffs, Sign-outs, and disasters. Emergency Medical News 2007; Feb 29(2): 10,12; Meisel ZF, Pollack C. Patient safety in emergency care transitions. (Case study). Emerg Med Specialty Reports 2006; S06178:1.

## Conclusion

Collaboration between the AOM and OMA to streamline and appropriately compensate midwives' direct referral to specialists will improve the client and provider experiences, responsibly steward tax dollars in the health system and contribute to improved health outcomes.

As evidenced by the strength of many models across the province, midwives are leaders in normal pregnancy and reproductive care. A joint strategy to build awareness among family physicians about midwifery will not only enhance the professions, but will provide the groundwork for a provincial strategy for low-risk pregnancy and reproductive care that recognizes the strengths, scopes of practice and opportunities for effective collaboration in the health system.

Collaboration between midwives and physicians can enhance access to primary care and improve the health of communities. Leveraging our shared goals of working collaboratively while putting clients' interests first supports a high-quality and cost-effective system for primary care in Ontario.

We appreciate the opportunity to provide these recommendations to the Primary Care Working Group and look forward to working together with the OMA to improve primary care for Ontarians.

Best Regards,

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