Provincial Council for Maternal and Child Health
building a brighter future

It's OK to be Normal!

Vicki Van Wagner, RM PhD

Best Start Resource Centre
February 19, 2016

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Agenda

1. **Overview of PCMCH**
2. **Creating a system's approach to care**
3. **It's OK to be normal!**
4. **Initiatives in other jurisdictions**
5. **Initiatives in Ontario**
6. **Connecting the dots**

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Overview of PCMCH

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Background and Overview of PCMCH

PCMCH Key Features

Target Population: Focused on the maternal-child population and successful transition to adulthood

Clinical Engagement: Work is supported by standing committees and focused, time-limited expert panels

Comprehensive Perspective: Council and advisory committees reflect all levels of care, and the full geographic diversity of the province

Service Continuum: Scope includes maternal, newborn, child and youth health care services across both community and hospital settings

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Background and Overview of PCMCH

Complementary but unique populations

While there are strong connections between maternal, newborn and paediatric systems, differences exist…

Maternal & Newborn:

- Broadly distributive provider system
- Population Health and primary care focused
- Horizontal / longitudinal

Paediatric

- Highly concentrated provider system
- Population Health and specialization of care focused
- Vertical

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Background and Overview of PCMCH

Maternal – Newborn Initiatives

Low Risk Maternal Newborn Strategy	Low Risk Birth QBP	Prenatal Screening Strategy	Standards of Post-Discharge Care
VBAC Pathways	Neonatal Follow-up Clinics	Mat & Newborn Levels of Care Evaluation	Neonatal Transport
	Antenatal Records	Baby Friendly Initiative	

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Creating a system's approach to care

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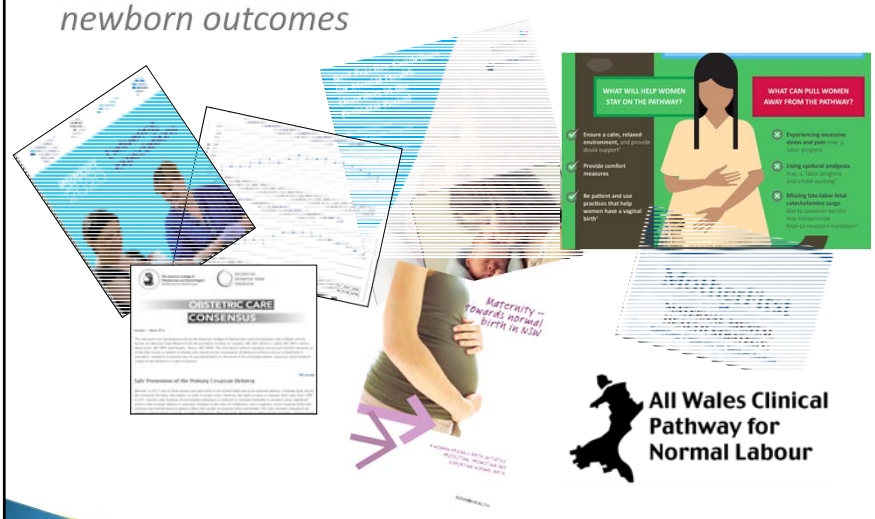
Creating a System's Approach to Care

Initiatives across the globe to improve maternal newborn outcomes



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Creating a System's Approach to Care

How do we make sense of it all in Ontario

Opportunities:

- Lots of innovation and efforts underway to standardize maternal newborn care
- Lots of effort to understand system challenges and gaps at a local, regional, provincial level
- Collaboration part of day to day work but still big gaps
- Passionate leaders who want to collaborate and make change!

Threats:

- Disjointed planning
- Collaboration is often an 'after thought' in planning
- Systems often not aligned

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Creating a System's Approach to Care

Creating common ground

How do we create common ground across sectors and professions to advance robust client-centred maternal newborn care (and choice) in Ontario?

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Creating a System's Approach to Care

Example: Low Risk Maternal Newborn Strategy

- Regional variation in practice and access to choice
- Challenged access to care in rural and remote areas
- No province-wide policies or strategies for low risk maternal and newborn care

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Creating a System's Approach to Care

Example: Low Risk Maternal Newborn Strategy

But we know….

- Maternal and newborn care is the foundation of a healthy beginning for mothers, babies and their families
- Services touch all families and have lifelong impact on Ontarians and their communities
- Childbirth is #1 cause of hospitalization in the province
  - 13% of all inpatient hospitalizations[1]
  - 21% of all days in the hospital

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1. Canadian Institute for Health Information. Inpatient Hospitalizations, Length of Stay, Surgeries and Newborn Indicators in 2013-2014.

Creating a System's Approach to Care

Example: Low Risk Maternal Newborn Strategy

PCMCH brought together stakeholders across the continuum of maternal-newborn care and across the province to join a Expert Panel to advise on the strategy. Members include representation from:

- Family physicians
- Midwives
- Nurses
- Obstetricians
- Neonatologist/Paediatrician

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Creating a System's Approach to Care

Example: Low Risk Maternal Newborn Strategy

The Patient Voice:

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Creating a System's Approach to Care

Example: Low Risk Maternal Newborn Strategy

Expected Outcomes - A framework that:

- Optimizes system/ provider practices that promote **"normal birth"**
- Promotes **equitable access** to normal pregnancy and birth services that is **woman/person and family-centred**
- Supports a system of care that provides women and their families with **equitable choice in birth environment and provider**

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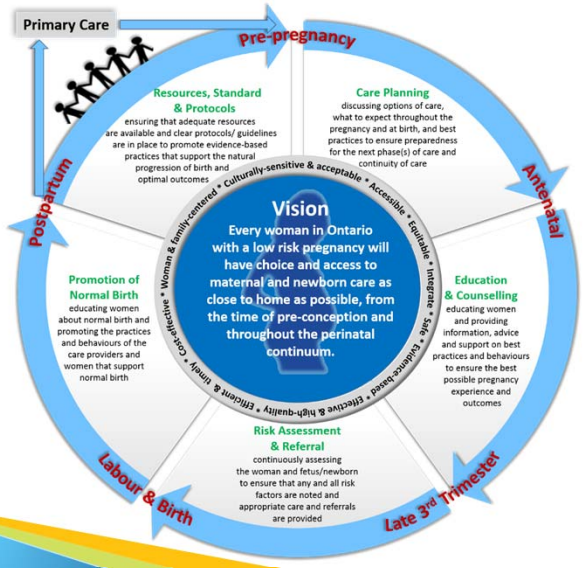
Creating a System's Approach to Care

Framework for Low Risk Maternal Newborn Care



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Why is promoting normal birth important to population health?

- There are societal and system level benefits of adopting a "normal birth" approach to labour and birth:
  - increasing breastfeeding initiation and duration rate outcomes
  - increasing optimal maternal infant attachment and bonding (supporting optimal infant growth and development potential)
  - decreasing risk of maternal and infant mental illness
  - decreasing late preterm births
  - decreasing immediate health care costs related to unnecessary interventions and long-term health care costs related to obesity and complex chronic diseases

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It's OK to be normal!

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It's OK to be normal!

What does 'normal' mean?

- Normal birth statements:
  - WHO 1996
  - NHS UK 2007
  - ICM 2008
  - SOGC 2008
  - CAM 2010
  - New Zealand 2006
  - NSW Australia 2010
  - ACNM – US 2012

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It's OK to be normal!

What does 'normal' mean?

WHO

- Labour is spontaneous in its onset
- Low-risk at the start and throughout labour and delivery
- Baby is born spontaneously in the vertex position between 37 and 42 gestation
- Following birth both mother and infant are in good condition

World Health Organization (1996). Care in Normal Birth: A practical guide. www.who.int/reproductive-health/publications/MSM_96_24/MSM_96_24_Chapter1.en.html

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RCM/RCOG/NCT definition

The '*normal delivery*' group includes:

- women whose labour starts spontaneously, progresses spontaneously without drugs, and who give birth spontaneously
- women who experience any of the following:
  - augmentation of labour
  - ARM if not part of medical induction
  - Entonox, opioids
  - **electronic fetal monitoring**
  - managed third stage of labour
  - antenatal, delivery or postnatal complications (PPH, perineal trauma, admission to SCBU or NICU)

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RCM/RCOG/NCT definition

The '*normal delivery*' group excludes:

- induction of labour (PG, oxytocics or ARM)
- **epidural** or spinal
- general anaesthetic
- forceps or ventouse
- caesarean section
- episiotomy

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JOINT POLICY STATEMENT

No. 221, December 2008

Joint Policy Statement on Normal Childbirth

This policy statement has been reviewed and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada (SOGC), the Association of Women's Health, Obstetric and Neonatal Nurses of Canada (AWHONN Canada*), the Canadian Association of Midwives (CAM), the College of Family Physicians of Canada (CFPC), and the Society of Rural Physicians of Canada (SRPC).

* The position statement was developed with input and endorsement from AWHONN Canada but has not received endorsement by AWHONN United States.

J Obstet Gynaecol Can 2008;30(12):1163–1165

INTRODUCTION

Normal (spontaneous) Delivery: (i.e., not assisted by forceps, vacuum, or Caesarean section, and not a malpresentation): It refers only to the type of delivery of the infant. It could, therefore, include induction, augmentation, electronic fetal monitoring, regional anaesthesia, and complications of pregnancy (hypertension, antepartum hemorrhage etc). That is, the labour may involve a complication or abnormality, but the delivery is normal (spontaneous).

Natural: The Compact Oxford English Dictionary[3] defines this as "Existing in or derived from nature; not made, caused by, or processed by humankind." Childbirth is considered to be natural childbirth if there is little or no human intervention.

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SOGC Joint definition includes:

- Augmentation of labour
- ARM if not part of medical induction of labour
- Pharmacologic pain relief (nitrous oxide, opioids and/or **epidural)**
- Non-pharmacologic pain relief
- Managed third stage of labour
- Intermittent fetal **auscultation**

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SOGC Joint definition excludes:

- Elective induction of labour prior to **41+0 weeks**
- Spinal analgesia
- General anaesthetic
- Forceps or vacuum assistance
- Caesarean section
- **Routine** episiotomy
- Continuous **EFM for low risk** birth
- Fetal **malpresentation**

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It's OK to be normal!

Evidence for normal birth initiatives

- BORN Ontario data
- BORN data focuses on the cohort of woman who are considered Low Risk, and therefore most likely to have a "normal birth"

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Population and Analyses

All data analyzed separately in two populations:

1. All women who gave birth in Ontario (2012-2014)
2. Low Risk women who gave birth in Ontario (2012-2014)
   - Robson criteria 1 to 4
     - Robson 1 - Nullipara, singleton cephalic, ≥ 37 weeks, spontaneous labour
     - Robson 2 - Nullipara, singleton cephalic, ≥ 37 weeks (induced or C-section before labour)
     - Robson 3 - Multipara, singleton cephalic, ≥ 37 weeks, spontaneous labour
     - Robson 4 - Multipara, singleton cephalic, ≥ 37 weeks (induced or C-section before labour)
   - Excluding the following health conditions:
     - Maternal - autoimmune, cancer, cardiovascular, diabetes, gastrointestinal, genitourinary, haematological, hypertensive disorders in pregnancy, musculoskeletal, neurological, placental, pulmonary
     - Fetal – anomalies or complications

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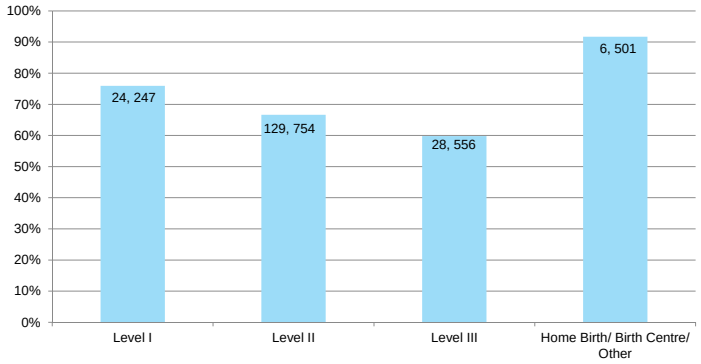
Overview of Low Risk Births

Proportion of all women who are low risk by location of birth (Ontario, 2012-2014)



Source: BORN Ontario

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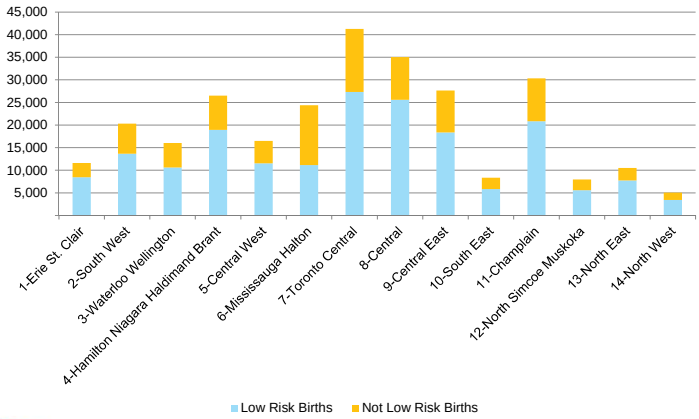
Overview of Low Risk Births

Number of low risk and not low risk births by LHIN (Ontario, 2012-2014)



Source: BORN Ontario

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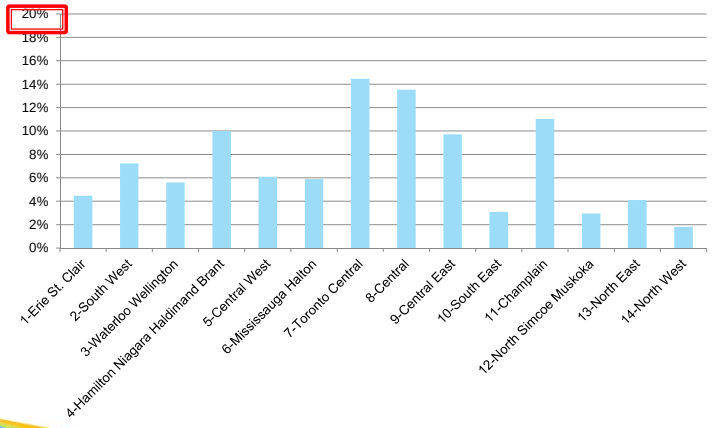
Overview of Low Risk Births

Distribution of low risk births across LHINs (Ontario, 2012-2014)



Source: BORN Ontario

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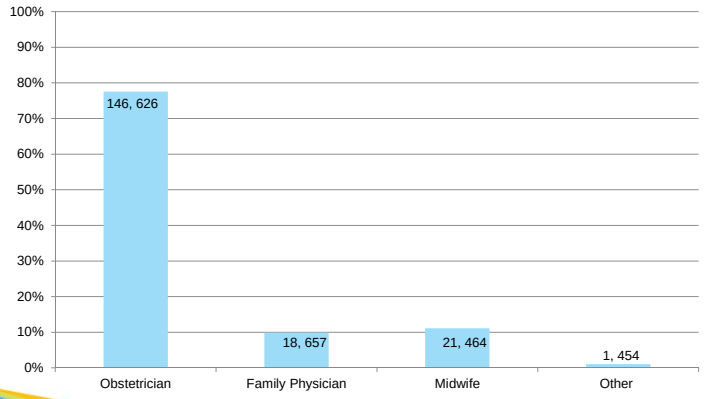
Overview of Low Risk Births

Distribution of low risk births across delivering healthcare provider specialties (Ontario, 2012-2014)



Source: BORN Ontario

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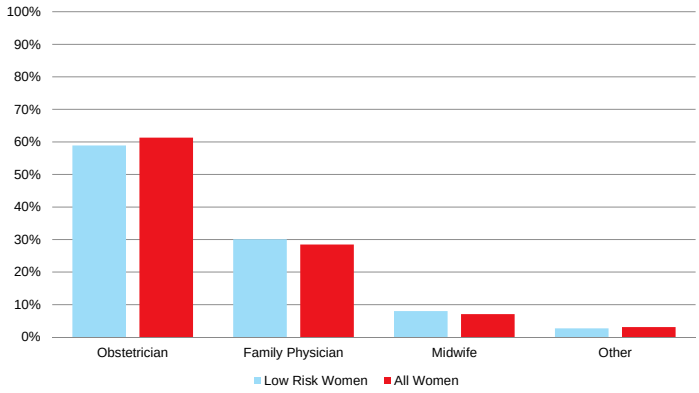
Overview of Low Risk & All Ontario Births

Distribution of births across delivering healthcare provider specialties in Level 1 hospitals (Ontario, 2012-2014)



Source: BORN Ontario

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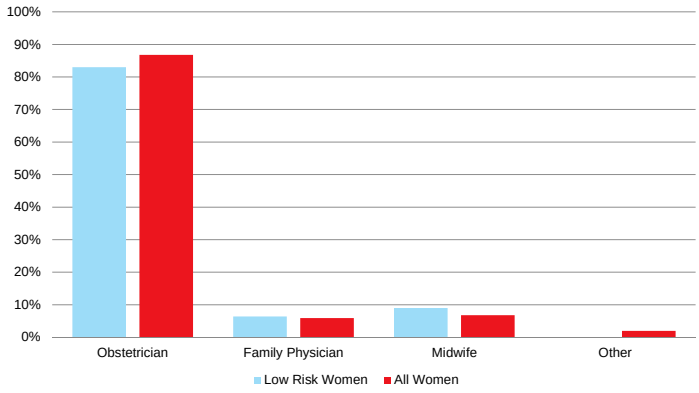
Overview of Low Risk & All Ontario Births

Distribution of births across delivering healthcare provider specialties in Level 2 hospitals (Ontario, 2012-2014)



Source: BORN Ontario

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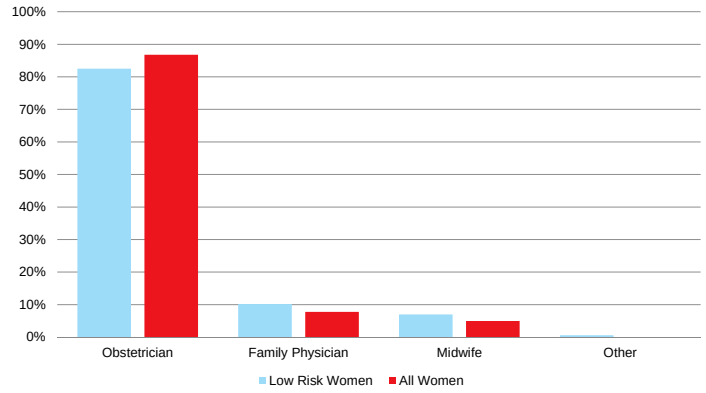
Overview of Low Risk & All Ontario Births

Distribution of births across delivering healthcare provider specialties in Level 3 hospitals (Ontario, 2012-2014)



Source: BORN Ontario

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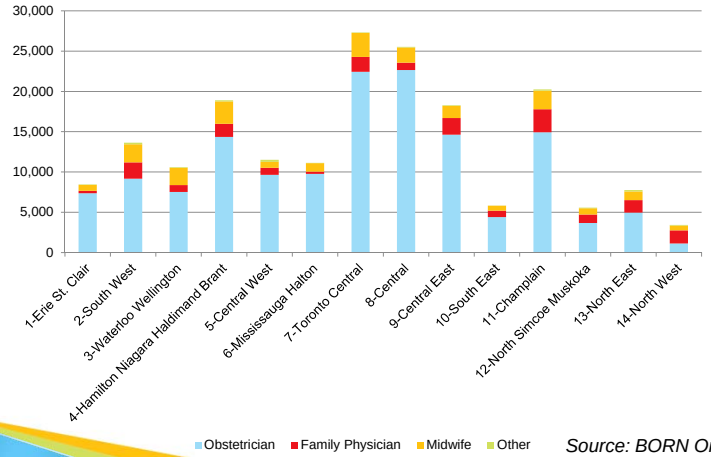
Overview of Low Risk & All Ontario Births

Distribution of the number of low risk births across delivering healthcare provider specialties by LHIN (Ontario, 2012-2014)



Source: BORN Ontario

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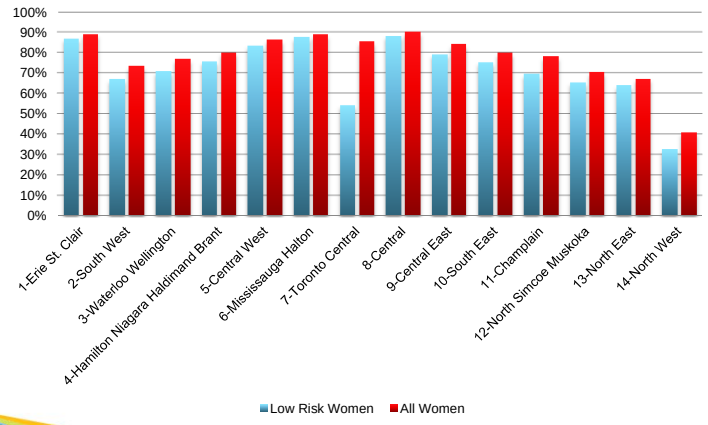
Overview of Low Risk & All Ontario Births

Proportion of births within LHINs delivered by an obstetrician (Ontario, 2012-2014)



Source: BORN Ontario

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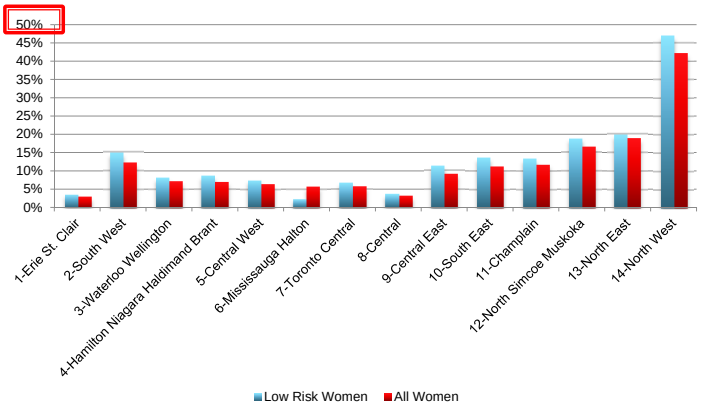
Overview of Low Risk & All Ontario Births

Proportion of births within LHINs delivered by a family physician (Ontario, 2012-2014)



Source: BORN Ontario

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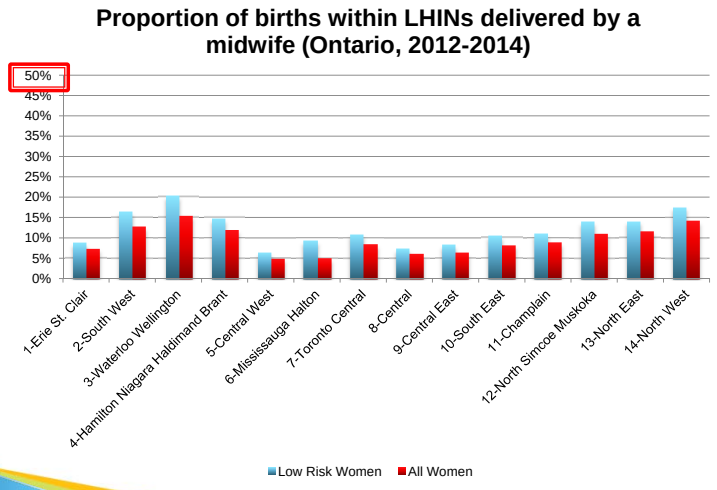
Overview of Low Risk & All Ontario Births



Source: BORN Ontario

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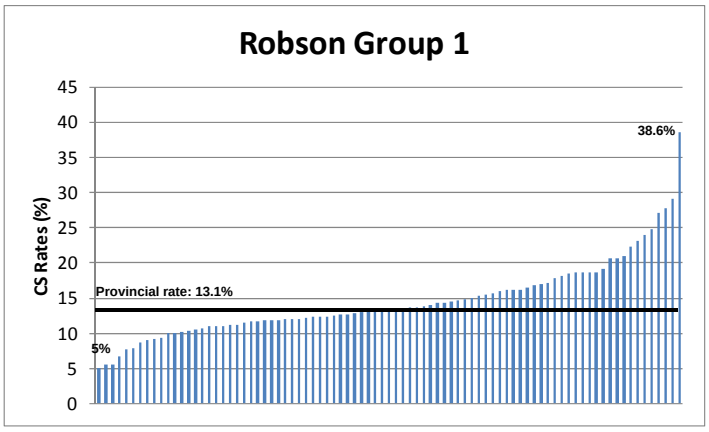
Review of Current Data

Hospital Specific CS Rates for Robson Group 1, Sorted in Ascending Order (2009-2014)



Note: 12 hospitals reported less <6 cases

Source: BORN Ontario

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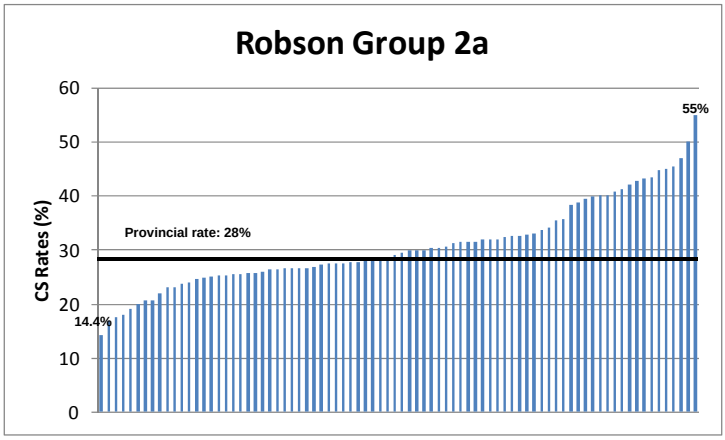
Review of Current Data

Hospital Specific CS Rates for Robson Group 2a, Sorted in Ascending Order (2009-2014)



Note: 15 hospitals reported less <6 cases

Source: BORN Ontario

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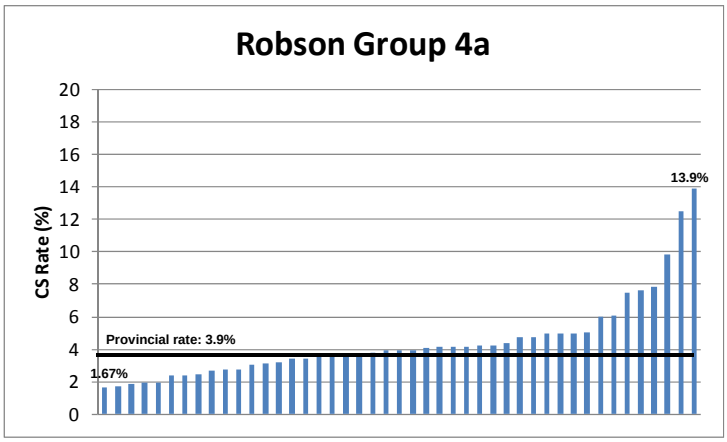
Review of Current Data

Hospital Specific CS Rates for Robson Group 4a, Sorted in Ascending Order (2009-2014)



Note: 52 hospitals reported less <6 cases

Source: BORN Ontario

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Review of Current Data

Primary Indication for CS

Rate of primary indication for Caesarean section for all women who delivered in Ontario by Caesarean section Ontario, April 1, 2012-Mar 31, 2014

Primary indication for cesarean section	%
Anomaly	0.2
Atypical or Abnormal Fetal Surveillance	14.9
Cord prolapse	0.4
IUGR	0.8
Macrosomia	1.1
Malposition/Malpresentation	12.1
Failed forceps / vacuum	0.5
Failed Induction	0.0
HSV - Herpes Simplex Virus	0.1
Hypertensive disorders of pregnancy - Eclampsia	0.1
Hypertensive disorders of pregnancy - HELLP	0.3
Hypertensive disorders of pregnancy - Preeclampsia	1.0
Maternal Health Conditions/s	1.0
Multiple gestation	1.1
Nonprogressive first stage of labour	10.7
Nonprogressive second stage of labour	5.4
Obesity	0.0
Other Obstetrical Complication	2.5
Placenta previa	1.9
Placental abruption	0.9
Prelabour Rupture of Membranes (PROM) in women with planned C/Section	0.1
Preterm prelabour rupture of membranes (PPROM) in women with planned C/Section	0.1
Previous C/Section	35.2
Previous uterine rupture	0.0
Suspected chorioamnionitis	0.2
Uterine rupture	0.1
VBAC - Declined VBAC	0.0
VBAC - Failed attempt	0.4
VBAC - Not eligible	0.0
Nonprogressive labour/descent/dystocia	1.6
Accommodates Care Provider/Organization	0.0
Maternal Request	4.9
Missing data	100.0
Grand Total	

Source: BORN Ontario

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Initiatives in Other Jurisdictions

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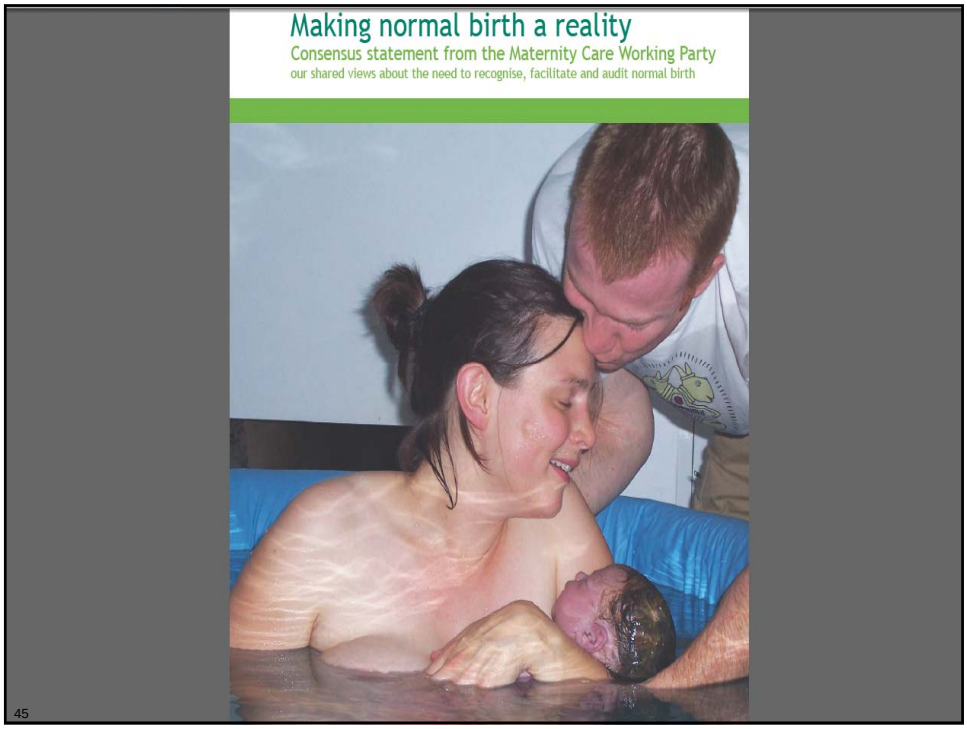

Initiatives in Other Jurisdictions

All Wales Clinical Pathway for Normal Labour

- Telephone advice
- Initial assessment
- Active labour pathway
- Women's leaflet
- Bibliography and reference
- Partogram

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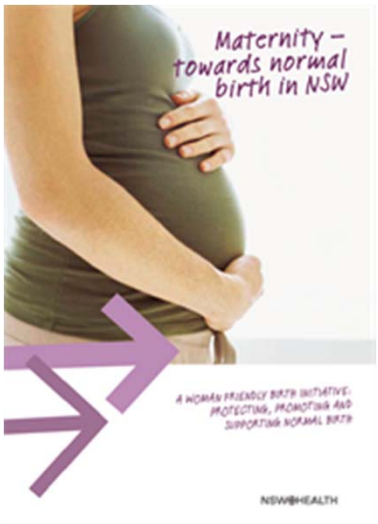
Initiatives in Other Jurisdictions



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www.theguardian.com/lifeandstyle/2014/dec/03/low-risk-pregnant-women-urged-avoid-hospital-births

UK world sport football opinion culture economy lifestyle fashion environment tech money travel all sections

home › lifestyle › health & fitness love & sex family women home & garden food

Childbirth

Low-risk pregnant women urged to avoid hospital births

NHS guidance from National Institute for Health and Care Excellence suggests 45% of births 'unsuitable' for labour wards

Haroon Siddique

Wednesday 3 December 2014 00.02 GMT

Shares 58k Comments 781

Low-risk pregnancy cases are being urged to avoid hospital birth under new NHS guidelines Photograph: Katie Collins/PA

Women with low-risk pregnancies are to be encouraged to have non-hospital births under new NHS guidelines, which could see almost half of mothers-to-be planning to deliver their baby away from traditional labour wards.

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ESSENTIAL EVIDENCE PLUS

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NICE guideline: Midwife preferred for low-risk pregnant women, including at-home for some

Clinical question

What is the optimal site for birth by low-risk women?

Bottom line

For healthy women who go into labor between 37 to 41 weeks', the United Kingdom's National Institute for Health and Care Excellence (NICE) advocates for delivery at a freestanding midwifery unit, citing lower interventions and similar outcomes. They also suggest birth at home for low-risk multiparous women. These recommendations are new for 2014. (LOE = 5)

Reference

Torjesen I. Midwife led delivery is safer than a labour ward for low risk pregnancies, says NICE guidance. BMJ 2014;349:g7421.

Study design
Practice guideline

Funding
Government

Allocation
N/A

Setting
Various (guideline)

Synopsis
The site of delivery of pregnant women varies widely around the world. In the United States and Austria, for example, deliveries are usually in a hospital and attended by obstetricians or family physicians. In the United Kingdom and Denmark, though, 70% to 75% of births are managed by midwives, where the midwifery networks are much more extensive. This new guideline from NICE indicates that women may choose any birth setting they prefer. The guidelines suggest that midwife delivery is "particularly suited" to low-risk nulliparous and multiparous women

Other Initiatives in Ontario

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Initiatives in Ontario

What's happening in Maternal-Newborn Care In Ontario

- Promoting normal birth
- Reducing Caesarean section rate variation across the province
- Enhancing the role of public health throughout all phases of maternal-newborn care
- Perinatal mental health

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Initiatives in Ontario

Low Risk Birth QBP: Overview and Context

Provincial Council for Maternal and Child Health

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It's OK to be normal!

The Low Risk Birth Quality Based Procedure

What are Quality Based Procedures?

- Clusters of patients with clinically related diagnoses or treatments who would benefit from process improvements, clinical re-design, improved patient outcomes, enhanced patient experience, and potential health system cost savings.
- Initially developed in the acute (hospital) sector, QBPs were defined as "procedures."

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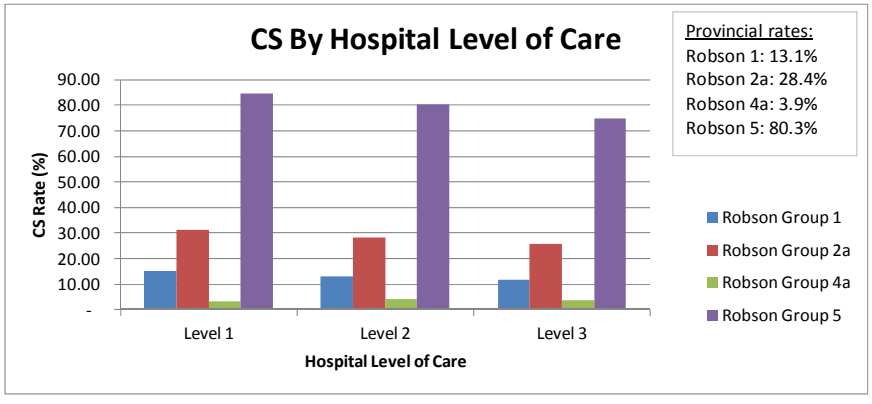
Initiatives in Ontario

Low Risk Birth QBP



Robson 1: *Nullipara, singleton cephalic, ≥ 37 weeks, spontaneous labour*
Robson 2a: *Nullipara, singleton cephalic, ≥ 37 weeks, induced labour*
Robson 4a: *Multipara, singleton cephalic, ≥ 37 weeks, induced labour*
Robson 5: *Previous Caesarean section, singleton cephalic, ≥ 37 weeks*

Source: BORN Ontario

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Initiatives in Ontario

Low Risk Birth QBP – Target Population

Modified Robson 1:

- <36 years of age at the time of delivery
- Pre-pregnancy BMI <40.0 kg/m^2
- Nulliparous
- Singleton gestation with cephalic presentation
- Delivery ≥ 37 weeks of gestation
- Spontaneous labour

Included several *exclusion criteria* such as maternal health conditions, pregnancy complications and fetal health conditions

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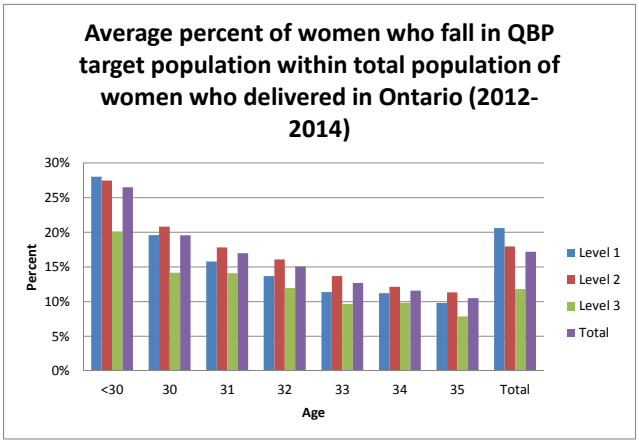
Initiatives in Ontario

Low Risk Birth QBP – Target Population



Source: BORN Ontario

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Initiatives in Ontario

Low Risk Birth QBP – Key Deliverables

- ***Draft clinical handbook*** with input from Expert Panel members, existing clinical guidelines and consensus statements to promote normal birth in low risk women
- ***Draft indicator handbook*** that includes three key indicators to measure outcomes in this target population for hospitals that implement this QBP

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Patients First

PCMCH Summit on Patients First and MNCH

- Keeping maternal child health on the agenda
- Healthy people first (as well as patients)
- Strengthening access to low risk maternity care
- Integrating LRMC into the primary care system
- Ensuring midwifery care is included in primary care initiatives
- Integrating public health and primary care
- Supporting collaboration

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Connecting the Dots

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Connecting the dots…

What are the maternal newborn priorities in Ontario?

- Local
- Regional
- Provincial

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Discussion

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Let's Talk!

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Provincial
Council for
Maternal and
Child Health
building a brighter future
Thank You!
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