Submission to the Premier's Council on Ending Hallway Medicine

Leveraging Midwives to End Hallway Medicine: Optimizing Scope, Transitioning Birth to Primary Care, and Delivering Care in the Community

Background

The Association of Ontario Midwives (AOM) welcomes the opportunity to provide feedback and recommendations to the Premier's Council.

Ontario'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. Midwives provide a seamless transition between hospital and home, and have great success coordinating and delivering care for families in Ontario in both acute care and community settings. The midwifery model of care boasts excellent clinical outcomes, and is a cost-effective use of taxpayer dollars and an effective way of cutting hospital wait times and ending hallway health care.

The AOM represents over 900 registered and Aboriginal/Indigenous midwives providing care in over 90 communities across Ontario.

Ontario midwives are publicly funded primary health-care providers who are specialists in providing around-the-clock, on-call care for clients throughout normal pregnancy, birth and the first six weeks after birth. Midwives are one of the only health care providers where the same provider follows the client/patient between community and hospital, depending on the needs of that client/patient[1].

This year, over 29,000 families will have the care of a midwife. Over 240,000 families have received midwifery care in the past 15 years[2]. 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 centres. They provide care that Ontario families deeply value. For example, a maternity care study showed very high rates of exemplary client experience in midwifery care[3],

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[1] Note: because those who seek midwifery care are healthy and do not have illness, the term "client" is used by midwives, rather than "patient".
[2] BORN Ontario. Midwifery Care Profile – Utilization of Services 2016-2017. 2019 May.
[3] Janssen P, Klein M, Harris S, Soolsma J, Seymour L. Single Room Maternity Care and Client Satisfaction. Birth. 2000 Dec; 27(4):235-243.

significantly higher than that of family physicians or obstetricians.[4] Moreover, midwifery clients have lower rate of interventions and shorter hospital stays. By offering birth at home or at birth centres, as well as providing successful vaginal birth after C-sections, Ontario midwives effectively reduce hospital stays and free up beds and hospital resources for those who need it most. The provision of high-quality care at lower costs by midwives aligns strongly with accountability care principles.

1. What do you think is working well, that you would *not* want to see changed?

Current Midwifery Model of Care

The current model of midwifery care has proven to be a highly successful method of delivering perinatal care: strong clinical outcomes, exemplary client experience and efficiency in the delivery of care. We recommend that the government continue to support this model of care and seek ways to expand on it, as this model is an important contributor to ending hallway medicine.

a. Reduced admissions to hospital for birth.

Birth is the number one reason for hospital admission.[5] To effectively bend Ontario's hospital cost curve, admission for hospital birth must be addressed by the Council. The provision of home birth by midwives has been a major success story for Ontario health care, with estimated cost-savings of approximately $2,338[6] per home birth. Thus, the AOM recommends that no changes interfere with this option for Ontario families, but rather that the government seek opportunities to expand access to home birth.

Midwifery provides opportunities for care, including labour and birth, to be provided out of hospital and into communities by providing the option of receiving care in the home, birth centres, and community based midwifery clinics. Between 2003 and 2018, over 41,000 midwifery clients gave birth at home. To put this into perspective, midwives attend about a fifth of all Ontario births (17%)[7], and roughly 20% of these births take place outside of

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[4] Public Health Agency of Canada. What Mothers Say: The Canadian Maternity Experiences Survey. Ottawa: 2009. P. 225

[5] 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

[6] 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

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

hospital.[8] Thus, the potential for growth in home and birth centre births is great and the resulting cost savings, even greater. A 2015 study that analyzed the costs of midwifery-attended home births and hospital births in British Columbia found that cost savings from one home birth was approximately $2,338.[9] Assuming 25,000 midwifery deliveries this year with a conservative 20% home birth rate, midwives will save the health care system an estimated $11.7 million this year alone.[10] There is still tremendous potential for further savings by increasing the awareness of the option of home birth and its safety, and by increasing the size of the midwifery workforce.

Birth Centres are also a major success story in Ontario; with 3 large birth centres fully operational in the province, there is a third option for midwifery clients while successfully diverting those clients from hospital. A recent BORN evaluative study showed excellent clinical outcomes and cost effectiveness of the birth centres in Toronto and Ottawa.[11]

b. Shorter Length of Stay, lower costly interventions.

Midwifery is associated with shorter hospital length of stay and lower costly interventions (for example, C-section – the most common in-patient surgery) than the provincial average.

i. Midwifery clients in Ontario had a 12% lower C-section rate and a 38% lower epidural rate than the provincial average in 2017.[12] The average length of stay for hospital births attended by midwives is approximately 1.8 days,[13] while the provincial average is 2.3 days.[14] This difference could be further enhanced if midwives were given appropriate equipment to provide in community care; the best example of this is the need for bilimetres so that midwives can provide appropriate newborn testing without the need for an increased length of stay to receive this test. With the right equipment, the length of stay of midwives could be further decreased. Similarly, greater cooperation from hospitals on providing access to standard tests and screens for newborn care through hospital outpatient services such as labs will result in earlier discharges and possibly even more out of hospital births. It will also

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[8] Idem.

[9] 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

[10] Idem.

[11] BORN Ontario. 2014-2016 Biennial Report. Research and Evaluation. 2016. Retrieved from: https://www.bornontario.ca/en/about-born/governance/annual-reports/2014-2016-annual-report/research-evaluation/

[12] Idem.

[13] Idem.

[14] 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

foster improvements in client safety and satisfaction through the provision of seamless and well-coordinated care.

ii. Midwives have higher rates of successful vaginal birth after C-sections (VBAC) which 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.[15]

c. Higher rates of client satisfaction; excellent client experience

Midwifery clients report significantly higher rates of exemplary client experience when compared to family physicians or obstetricians. [16] Many reasons are likely for this including longer visit times, 24/7 availability from a known midwife, and the informed choice approach to information-sharing and decision-making.

d. Diversion from ER 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. [17] [18] [19]

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

[16] Public Health Agency of Canada. What Mothers Say: The Canadian Maternity Experiences Survey. Ottawa: 2009. P. 225

[17] 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

[18] 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.

[19] 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.

Strengthen publicly funded health care

The AOM supports Minister Elliott when she clearly stated "*There will be no more for-profit care in the system that we are envisioning.*"[20] Midwives will not support further privatization of Ontario's health care system. Extensive research on privatization of health care demonstrates that this benefits those who will reap the profits from their private enterprise, but does not benefit patients or the health care system as a whole.[21]

2. What local innovations in health care are you aware of that might help improve/change the way we deliver health care in the future?

Midwifery as a model for other kinds of care

Midwifery itself is a major innovation in perinatal care. This model of care puts the client as the central decision-maker for their care, provides the client with fully informed choice for all decisions related to their care, provides them with open access to their health care record, and provides one midwife who will, as their primary care provider, follow them to wherever they wish to give birth, will answer a page from the client 24/7 and will come to their home for assessment whenever it is required. It also gives full autonomy to this non-physician provider to diagnose, prescribe, order tests, admit and discharge from hospital. This model can be used as an innovative model for other kinds of care such as palliative care and seniors care where care could and should be centered in the community.

Educational Campaign to promote home birth

The public is largely unaware about normal birth and birth choices. The resultant culture of hospital-based and medicalized births costs our health care system far more than if all normal births were attended by low-risk, community-based primary care providers, including midwives. Since births are the number one reason for hospitalization, accounting for over 13%[22] of all inpatient hospitalizations, it is in the government's and public's interest to invest in public education media

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[20] Grant, K. (2019, February 26). Ontario Health Minister reveals major health care overhaul with new super agency. *The Globe and Mail*. Retrieved May 01, 2019, from: https://www.theglobeandmail.com/canada/article-ontario-health-minister-reveals-major-health-care-overhaul-with-new/

[21] Government of Canada. Building on values, the future of health care in Canada: final report.Ottawa:2002 Retrieved from: http: //publications.gc.ca/pub?id=237274&sl=0

[22] 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

campaigns that enhance the understanding of midwifery and choice of birthplace. In 2018, the Ministry funded an AOM designed and administered ad campaign that promoted home birth as a safe option for birthing parents. The one month campaign was highly successful regarding the reach of the campaign; however, further work to increase awareness is needed in order to change a century old culture of fear and distrust of home birth. The AOM recommends the government further invest in such educational media campaigns to assist in increasing the home birth rate in Ontario, thereby increasing cost savings from unnecessary hospital admissions.

3. How do you think most people will want to interact with their healthcare providers in the future?

Evaluation studies of midwifery care help to inform our opinion here. The client satisfaction rate is very high in midwifery care, significantly higher than that of family physicians or obstetricians.[23] Midwives attribute this to the continuity of care model, the time provided per visit, the 24/7 on call availability of the midwife, and the strong tenet of informed choice in all interactions with the client. The AOM recommends that the Council look to the midwifery model of care for how other patients would want to interact with their health care providers in the future.

In particular, we encourage the Council to think about how 24/7 on call availability to assess someone in their home at all times of the day or night could be provided. This call model is key to keeping people out of emergency rooms for issues that do not require emergent care, and for addressing issues early and quickly in the community so they do not become emergencies.

4. How do you think people can best be supported to remain longer in the community while receiving treatment/care?

As the only province-wide primary health care professionals who provide continuity across both the hospital and community sector on a 24/7 basis, midwives possess unique expertise in coordinating care for effective and excellent delivery of health services. As a result, midwives are ideally positioned to assist and advise the government with developing this new system of care.

Midwives have 25 years of experience providing care that keeps clients out of emergency rooms by being on-call 24/7, making home visits for clinical assessments, and offering out-of-hospital options for care. Midwives excel in ensuring seamless transitions between home, community and hospital, while providing a top quality client experience. This model could be particularly helpful in seniors care, mental health care, cancer and palliative care where continuity of provider, informed choice about one's health care, and a choice of place to receive care can reduce hallway medicine, and deliver excellent clinical outcomes and exemplary client experience.

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[23] Public Health Agency of Canada. What Mothers Say: The Canadian Maternity Experiences Survey. Ottawa: 2009. p225

Demand for midwifery has always outpaced supply. Nearly four in ten of those requesting midwifery care are not able to access a midwife due to this shortage. Growth in underserviced areas is of particular importance because health care providers are few and overworked, serving populations over greater distances. Growing midwifery in such areas would help alleviate the burden placed on under-resourced hospitals and burned-out health care providers. The AOM recommends an increased investment in midwifery care so it can meet the demand for care from Ontarians.

Medically unnecessary forced evacuation

Midwives have also demonstrated expertise in northern communities, providing timely and effective care where it is most needed, together with other committed health professionals. Birth care in rural, remote and Far North communities must be led by experts in birth care and community health. Thus, we would like to see Ontario protect and maintain local health care services in small towns and remote areas by supporting registered and Aboriginal midwives.

The AOM recommends the Council to review the practice of medically unnecessary forced evacuation in northern Indigenous communities. This practice, coined the "residential schools of medicine" has detrimental effects on neonatal and maternal health.[24] It widens the gaps in health care access for pregnant Indigenous people that is already exacerbated by distance to a maternity care facility, thus resulting in worse health care outcomes compared to non-Indigenous groups.[25] This practice could be eradicated, at considerable cost savings to the government if Indigenous midwives are trained from those communities and supported to stay to provide perinatal care in the community.

b. Are there any risks and/or unintended consequences the Council should consider when reviewing the proposed actions?

There are significant risks in making changes to the system without understanding the unique and valuable role played by the primary care sector in keeping people out of hospital. This risk will be exacerbated if control of the OHT system, for example, is given to the hospital sector; this can result in priorities that skew against health promotion and illness prevention activities which are the most cost effective interventions the government can make to ensure the health of Ontarians.

Similarly, control of OHTs or other integrated care delivery systems should not be placed solely in the hands of physicians. The Council should not assume that physicians must be leaders in this new health care system. In fact, there is research to demonstrate that this is not necessary:

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[24] Lawford, K.M., Giles, A.R., & Bourgeault, I.L. (2018). Canada's evacuation policy for pregnant First Nations women: Resignation, resilience, and resistance. *Women and birth : journal of the Australian College of Midwives, 31* 6, 479-488 .

[25] Idem.

> "…studies have highlighted the importance of diverse, collaborative governance structures to foster coordinated communication across the ACO [Accountable Care Organizations]. These governance structures would have representation from a wide array of specialties and stakeholders, including leaders in the community." [26][27]

5. What additional actions are required to help solve the challenges identified in the Council's first report? How do these actions support the emerging themes of:

i. Integration: There is a pressing need to integrate care around the patient and across providers in a way that makes sense in each of our communities across the province and improves health outcomes for Ontarians.

We see parallels to the government's vision for Ontario Health Teams with how midwives use the principles of continuity of care across place of care, informed choice and client choice of birth place. There are several key actions that will support this vision.

Action: Optimize the Scope of practice of Ontario's health care professionals

Midwives still face barriers to providing care to clients due to hospital integration and privileging issues, where hospitals impose medically unnecessary restrictions on midwifery privileges. These unnecessary restrictions on privileges undermine and underutilize midwives who are prevented from practicing to their full scope. For example, 52% of midwives are unnecessarily prevented from working to their full legislated scope[28] , such as managing epidurals and inductions, (skills that midwives are trained for) which leads to unnecessary systems-level costs and increased risk to patient safety. [29][30][31] Underutilizing midwives' skill and knowledge creates inefficiencies that undermine the intentions of Bill 74. Unnecessary transfers of care and physician consultation cost the system more, placing more demands on an overburdened system and leading to a delay in care for Ontarians. Care coordination by midwives is an essential part of an integrated and efficient

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[26] Jabbarpour Y, Coffman M, Habib A, Chung,Y, Liaw W, GoldS, Jackson H, Bazemore A, Marder W. Advanced Primary Care: A Key Contributor to Successful ACOs. Patient-Centered Primary Care Collaborative (Internet]. 2018 August. https://www.pcpcc.org/sites/ default/files{resources/PCPCC%202018%20Evidence%20Report.pdf

[28] Ontario Midwifery Program. Hospital Integration Survey. 2011.
[29] Sandall J, op.cit.
[30] Greenberg CC, et al, op cit.
[31] Glauser J., op cit.

health care system. The AOM recommends that government create benchmarks in OHT accountability agreements that measure both the percentage of midwives providing care and their ability to manage epidurals and inductions when necessary.

Action: Expand the scope of practice of Ontario's health care professionals

To deliver on this new vision of health care, the government must ensure that all health professionals are able to work in their fullest scope of practice. Current limitations on scope of practice are barriers to this transformation, including existing delays in approving new regulations regarding lab and drug prescribing. Improving access to lab and drug prescribing eliminates the duplication of services and ends unnecessary extra visits for Ontarians.

Other barriers that midwives face as primary care professionals is their restriction on directly consulting with specialist physicians. There are no OHIP billing codes for many midwifery-requested assessments, thus clients must be referred to family physicians or obstetricians who can request specialist consultations. This practice creates delays in accessing care for midwifery clients, creates confusion within interdisciplinary teams when specialists wonder why midwives cannot directly refer, undermines midwifery scope, breaks down communication when midwives have to make special requests to OBs and FPs to obtain results, and contributes unnecessary costs to the health care system. To illustrate, when a client requires a routine referral for follow up at a gestational diabetes clinic, an obstetrical referral is needed first, in order for the OB to make a referral to an endocrinologist. This costs our health system more, creates delays in care and reduces client satisfaction.

The AOM recommends that the Council review access to lab and drug prescribing, and expand OHIP Schedule of Benefits to allow professionals to work in their fullest scope in order to eliminate the duplication of services and end unnecessary clinic or hospital visits for Ontarians. The government must ensure that new Ontario Health Teams will only be approved if they ensure health providers will be optimized in the system and will not restrict their scope of practice, forcing medically unnecessary transfers of care that undermine this government's vision of a "relentless focus on the patient experience".

ii. Innovation: Growing demand and opportunity to innovate in care delivery, particularly in the use of virtual care, apps, and ensuring patients can access their own health data.

The AOM looks forward to the government's actions to increase secure access to more digital health services, including an integrated patient record system for Ontario. Patient-centered digital

records are an essential step towards facilitating collaboration and seamless care. An integrated EMR system is also necessary for measuring provider performance through performance metrics built into the system. It can offer timely feedback on provider performance, effectively tying into the goal of improved patient outcomes and satisfaction. Midwives need an integrated EMR system, as well as the need for funding that will facilitate its time-consuming and time-sensitive training. Equitable access to this technology and training across all sectors is paramount to providing a safe and positive patient experience in a system that is truly integrated.

The AOM supports client access to their own health care records and data – this in fact has been the model of record-keeping practiced in midwifery care for the past 25 years with great benefit to the client-midwife partnership, to the quality of care received by clients and likely to the quality of charting by the midwife. Midwives would be more than pleased to support their colleagues by sharing lessons learned with other parts of the health care system on how this can be done.

iii. Efficiency: The potential for greater efficiency in how we streamline and align system goals to support high quality care.

a. Long-term Capacity: The critical role for a long-term plan so that we have right mix of professionals, services, and beds to meet our changing health care needs.

Action: Create a maternity care strategy

Maternity care is a microcosm of health care in Ontario; it remains fragmented with deep inefficiencies. Ontario spends about $1B per year on maternity care services, yet there is no concentrated effort to implement a province-wide strategy to better plan for maternity care services. The AOM recommends the creation of a provincial maternity care strategy that leverages midwives' expertise and midwifery's proven clinical outcomes and that has a focus on ensuring that all pregnant people receive care from a primary care provider, and that those that need it have access to a specialist as well.

Action: Increase the number of midwives to meet demand by Ontarians

As front-line health care providers, midwives are a key element to ending hallway medicine through our efficient use of scarce healthcare resources, our commitment to keeping clients out of emergency rooms by being on-call 24/7, our provision of home visits for clinical assessments, and our expertise in providing safe and cost-efficient alternatives to expensive medical interventions.

Midwifery in Ontario was founded on principles of sustainable health care. Compared to Ontario's averages, the rates of clients requiring costly interventions like inductions, epidurals, and C-section

are all far lower for those in midwifery care. C-section is the most common surgery in Ontario[32], accounting for over 38,000[33] surgeries per year and steadily increasing. However, the increase in C-sections has not improved neonatal outcomes and has been associated with increased maternal morbidity.[34] Growth in midwifery care can help change that.

Action: Re-align high risk specialists away from low risk care

Similarly, highly trained obstetricians attend over 80% of all births, yet at least 60% of these births could be attended by low-risk providers like midwives and family physicians.[35] With Ontario's commitment to a sustainable health care system, the misalignment of high-risk, specialist care providers attending low-risk births can diminish and pave the way for appropriate providers caring for pregnant people based on their needs. The AOM recommends that the Council support a change in health care human resource planning that shifts the role of obstetricians from attending mostly low-risk pregnancies and births to one that values their expertise in caring for high-risk pregnancies and births.

Action: Develop a health human resource plan for maternity care

A key success factor in this transformation is the government's leadership in appropriate health human resource planning. This transformation will be best supported by investment in the health care providers who have the experience and commitment to providing this kind of care to Ontario's families. For example, Ontario's Registered and Indigenous/Aboriginal Midwives effectively reduce lengths of hospital stays, costly interventions, and free up beds and hospital resources for those who need it most. Ontario Health Teams will need access to a different mix of health care providers than are currently in the province if this vision is to work. A diverse and community-responsive health care workforce is required to meet the unique needs of families and communities.

Action: Work in Collaboration with Indigenous Healthcare Leaders

Indigenous community leadership prioritizing care in community, on a local level, is the key to a successful health system. While the preamble to Bill 74 states that this legislation will "recognize the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities", we recommend that the Council be explicit about creating and protecting

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[32] Hospital Morbidity Database, 2016–2017, Canadian Institute for Health Information. Retrieved from: https://www.cihi.ca/sites/default/files/document/hospch-hosp-2016-2017-snapshot_en.pdf
[33] Idem.
[34] Liu S, Liston R, Joseph K, 11. Ontario Midwifery Program. Hospital Integration Survey. 2011. Heaman M, Sauve R, Kramer M. Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term. Can Med Assoc J. 2007; 176:455-60.
[35] BORN Ontario. Provincial Overview of Perinatal Health in 2011-2012. 2013 Oct.

Indigenous-led models of health care. Evidence is clear that the health of communities begins with a fully integrated, culturally-safe model with families at the center. The AOM recommends that the government ensure this health care transformation fully takes into account and collaborates with Indigenous leaders currently addressing Indigenous health in general, and Indigenous Midwifery in particular. Newly funded models of Indigenous Midwifery are restoring health to their communities and we urge government to continue and regularize this essential service to Ontario's Indigenous communities. The upstream health benefits of healthy pregnancies, keeping birth as close to home as possible, and supporting early parenting and newborn health can play an important role in reducing health disparities for Indigenous peoples.

We recommend the Council ensure that health care transformation fully take in to account and work in collaboration with leaders currently addressing Indigenous health.

Summary

The Association of Ontario Midwives looks forward to working with the Council and the government to assist in creating a high performing system. In summary, our recommendations that we believe will be useful to the Council as it moves forward with further actions are as follows:

1. That the government continue to support the midwifery model of care and seek ways to expand on it, as this model is an important contributor to ending hallway medicine.
2. That no changes interfere with the option of home birth for Ontario families, but rather the Council seek opportunities to expand access to home birth.
3. That the government further invest in educational media campaigns to assist in increasing the home birth rate in Ontario, thereby increasing cost savings from unnecessary hospital admissions.
4. That the Council look to the midwifery model of care for how other patients would want to interact with their health care providers in the future; in particular, we encourage the Council to think about how 24/7 on call availability to assess someone in their home at all times of the day or night could be provided.
5. That the government make an increased investment in midwifery care so it can meet the demand for care from Ontarians.
6. That the Council review the practice of medically unnecessary forced evacuation in northern Indigenous communities and move to eliminate this practice by training Indigenous midwives from those communities and supporting them to stay to provide perinatal care in the community.
7. The government must ensure that new Ontario Health Teams will only be approved if they ensure health providers will be optimized in the system and will not restrict their scope of

practice, forcing medically unnecessary transfers of care that undermine this government's vision of a 'relentless focus on the patient experience.'

8. That the Council ensures that midwives are able to access hospital privileges and work in an environment that supports optimizing midwifery scope.
9. That the government create benchmarks in OHT accountability agreements that measure both the percentage of midwives providing care and their ability to manage epidurals and inductions when necessary.
10. That the Council review access to lab and drug prescribing, and expand OHIP billing codes for direct midwifery-led referrals to allow professionals to work in their fullest scope, eliminating the duplication of services and ending unnecessary extra clinic or hospital visits for Ontarians.
11. That the government create a provincial maternity care strategy.
12. That the Council support a change in health care human resource planning that shifts the role of obstetricians from attending mostly low-risk pregnancies and births to one that values their expertise in caring for high-risk pregnancies and births.
13. That the Council ensure that health care transformation fully take into account and work in collaboration with leaders currently addressing Indigenous health.

Respectfully submitted,

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