Operational Guideline for Collaborative Practice between Public Health Nurses and Midwives – Perinatal Services

EVIDENCE INFORMED PRACTICE TOOLS

June 9, 2017

http://www.wrha.mb.ca/extranet/publichealth/files/PHNsandMidwivesPerinatalServicesJune2017.pdf
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PURPOSE AND INTENT

This guideline is intended for use by Public Health Nurses (PHN) and Registered Midwives (RM) and it is founded on the principles of collaboration. Collaboration has been shown to improve health outcomes across all sectors of care, increase job satisfaction, and cut health care costs. It is built on six competencies: inter-professional communication, client centered care, role clarification, team functioning, collaborative leadership and inter-professional conflict resolution. These competencies provide a framework that strengthens relationships between care providers while enhancing the quality of care and satisfaction of all involved.

1. Introduction

Everyone wants to live a healthy and satisfying life. Complex social and medical factors can interfere with this. The more complex the needs, the less probable it is that one health care provider can meet them and the more important it is to facilitate a collaborative approach. There are various agencies and professionals that can make up the perinatal team for a client. Principles used here can be extended to collaboration with any other health care provider or agency.

2. Background

Midwives and Public Health Nurses have been collaborating to provide the best care for pregnant individuals and their families since midwifery was regulated in Manitoba. Since that time, collaboration has evolved and there is a growing emphasis on it within the WRHA and a need to enhance team effectiveness. Collaboration is a process that can be learned and evaluated with a standardized evidence informed framework. This guideline is meant to give practical step by step guidelines to assist with day to day collaboration as well as to provide knowledge of the behind the scenes competencies which when mastered will provide success in any collaborative relationship.

There is overlap in services offered by PHN’s and RM’s. Collaboration is meant to be a cost effective tool that allows each participant to work to their full capacity. It is not meant to be a duplication of services. Ideally every pregnant person should have access to both PHN’s and RM’s, but that is not possible at this time due to a lack of resources. As there are large gaps in the Winnipeg Regional Health Authority between those experiencing the best and the poorest health outcomes, a good way to know where to spend resources is to look through a health equity lens. This approach is in keeping with both PHN’s and RM’s mandates and will ensure that those with the most unmet needs get the support they need to improve their health outcomes. Inter-professional collaboration will result in increased prenatal referrals to midwifery and public health for disadvantaged populations and improved health outcomes.
3. Guiding Principles

The CIHC National Inter-professional Competency Framework describes the competencies required for effective inter-professional collaboration. The following six competency domains highlight the knowledge, skills, attitudes and values that together shape the judgments that are essential for inter-professional collaborative practice. The competency framework can be used to guide successful collaboration between Public Health Nurses and Midwives. If an issue is arising or collaboration is not going well, chances are one of these competencies is lacking.

A. Inter-professional Communication:
PHNs and RMds communicate with each other in a collaborative, responsive and responsible manner.
- Information is openly, willingly and respectfully shared according to PHIA to enable a holistic and client-centred family assessment of strengths and needs.
- Frequency of communication may be less important than the appropriateness, timeliness and mode of communication. Communication can take place in person, over the phone, or via pagers or faxes and preferences should be discussed and planned at the onset of the RM/PHN relationship. Clients have access to RM 24/7. Pagers should not be used for non-urgent calls.

B. Client Centered Care:
RMds and PHNs integrate and value the engagement of the client in planning for and delivering services.
- Support the participation of clients as integral partners in care.
- Share information with clients in a respectful manner and in such a way that it is understandable, encourages discussion, and enhances participation in decision-making.
- Ensure that appropriate education and support is provided to clients and others involved with care or service.
- Listen respectfully to the expressed needs of all parties in shaping and delivering care or services.
- Provide comprehensive advocacy and support to ensure clients remain engaged in their provision of care.

C. Role Clarification:
RMds and PHNs understand each other’s roles and use this knowledge appropriately to establish and meet client goals while decreasing duplication of services.
- PHN’s are able to share the role of RM’s to their clients, and RM’s will be able to share the role of PHNs to their clients.
- As scope and roles change within perspective professions it is important to have program wide meetings to keep informed and updated.
As midwives’ scope precludes prescribing many medications and performing operative deliveries it may not be appropriate to refer a client who is in need of a caesarean or has complex medical needs.

Each team member takes responsibility and accountability for their role and the tasks they provide.

D. Team Functioning:
RMGs and PHNs work as a team to provide client centered care. The RMGs and PHNs relationship, respects ethical values and every member’s participation in the collaborative decision making process. The collaborative nature of the PHN/RM working relationship provides enhanced professional satisfaction.

- Dedicated time for team development activities is facilitated. This could be accommodated by shared education days.
- Shared space to work/socialize together is provided. At facilities where PHNs and RMs share the building they can participate in team meetings to review client case care.
- Care is organized according to the goals of the client.
- Clear role statements for all team members assist to minimize duplication of service.

E. Collaborative Leadership:
RMGs and PHNs understand and apply leadership principles that support collaborative practice.

- Each individual is accountable for one’s own actions, responsibilities and role as well as facilitating the care needed by the client. The RM and PHN work collaboratively to determine who will provide case management while at the same time value the role of each team player.
- Clear team goals are linked to better team performance
- Organizational support of teams and sufficient training result in improved satisfaction and effectiveness. Opportunities for shared learning/workshops facilitate collaborative practice.

F. Inter-professional Conflict Resolution:
RMGs and PHNs actively engage self and others, including the client in positively and constructively addressing disagreements as they arise. Team members address conflict in a constructive manner.

- Establish a safe environment to express diverse opinions and understand strategies to deal with conflict.
- Identify potential conflicts across professional roles, providing an opportunity for continuous quality improvement.
4. Components

4.1 Prenatal Referrals

4.1.1 Prenatal Referrals from PHN to RM:

PHN role:

The PHN reviews all prenatal referrals and makes initial contact with the client via the telephone or home visit. The PHN assesses client readiness, preference, needs, existing resources and goals to determine the type, frequency and duration of services.

If the client is experiencing barriers to accessing services from a primary health care provider or is socially complex, a referral to midwifery services can be offered. See Appendix One for an example of how to introduce midwifery care to the client.

If the client accepts the prenatal referral to RM care, the PHN will support the client to complete the intake form ensuring that the referral source, contact and any information related to special needs are provided. The completed form is to be faxed to the Midwifery central intake line at 204-594-0907. The PHN will have access to a paper version of the midwifery intake form and can fill this out with the client as necessary (for example, the client does not have access to a phone or would benefit from assistance completing the intake process. See Appendix Three.

If it is deemed necessary to expedite the referral process, for example if the client has had no prenatal care and is close to her delivery date, in addition to faxing the referral form, the PHN can contact the midwifery practice closest to the client and speak directly with the midwife at the office to see if there is a spot available. PHNs are to call the office numbers (Appendix 6) as opposed to pager numbers, as on call RM’s may be in the middle of a delivery or sleeping after a long night of working.

The RM will return the call during weekday office hours as soon as possible. If accepting care, the RM will complete the task assigned to the intake form, contact the client for an initial interview in which the client and the RM will decide if the client is appropriate for RM care. If the client is accepted in to midwifery care, the RM will inform the PHN and discuss a care plan. If the referral is not accepted, the PHN will receive a call from the Birth Centre Assistant (BCA) within three weeks. The PHN will then need to facilitate access to an alternate care provider. There can be a three week or more turn around period from referral to acceptance into midwifery care. PHNs will use clinical judgement to determine whether or not the client also needs a referral to an alternate HCP before knowing if the client will be accepted into midwifery care.
Referrals to RM’s can be made at any point in the pregnancy. PHN referrals to midwifery should only be made for disadvantaged clients and the client should be made aware that the referral does not guarantee an acceptance into midwifery care as RM’s have a limited capacity.

The RM’s Role:

All RM’s will receive the referral via a task from the BCA or a telephone call from the PHN if the PHN would like to expedite the process. The RM’s caseload will be reviewed to determine availability. Every effort will be made to accommodate the client. The client will be contacted within two weeks to arrange an initial prenatal visit if accepted into care. RM’s are experts in low risk obstetrics and the decision to accept a client into RM care can only be made after an initial interview between the client and the RM to determine she is appropriate for RM care. If the caseload is full for the RM, the client will receive a letter declining care within three weeks. The BCA will also inform the PHN. The PHN will continue to work with the client to ensure access to a primary provider.

If the client is accepted into RM care the RM will contact the PHN via the contact number on the intake form. Together, the PHN, RM and client will make a plan for collaborative care. The plan will be client centred and will include preferred communication methods and plans for separate or combined care visits.

The RM will arrange ongoing prenatal care and check in frequently with the client to get updates on how things are going and encourage contact with the PHN. Ongoing communication between the client, the PHN and the RM may be minimal unless concerns or complexities arise.

4.1.2 Prenatal Referrals from RM to PHN:

RM’s role:

The RM explores the needs and preferences of clients during initial contact. PHN services are offered to disadvantaged clients only. The RM will use the risk factors as outlined on the Families First Screening Form (Appendix Eight) to determine which families to refer to PHN services. Families with 3 or more risk factors should be offered a referral to Public Health. The RM notes the risk factors/health inequities identified on the prenatal referral to the PHN. See Appendix Two for example of potential invite to PHN services.

The Prenatal Referral Form (Appendix Four) is to be completed with any details shared about how the PHN will best serve the client’s needs. The referral form will have the RM’s contact information and will be faxed to Public Health central intake. Referrals can be made at any point in the pregnancy and can be declined by the client at any time.
**PHN’s Role:**

The PHN receives and reviews the prenatal referral. The PHN contacts the RM to discuss the referral, client needs and collaborative care. The PHN makes initial contact with the client via the telephone or home visit within two weeks of receipt of the prenatal referral as per the Provincial Public Health Nursing Standards: Prenatal, Postpartum and Early Childhood. [Link](http://www.wrha.mb.ca/extranet/publichealth/files/MBPHNStandards_PrePostEarlyYears.pdf)

The PHN assesses client readiness, preference, needs, existing resources and goals to determine the type, frequency and duration of services. The PHN will then contact the RM to update on care plans and collaborate as necessary based on the needs of the client. Ongoing communication between the client, the PHN and the RM may be minimal unless concerns or complexities arise.

### 4.2 Postpartum Referrals:

**PHN’s Role:**

The PHN receives Postpartum Referral Forms (PPRFs) from midwives via Central Intake within 48 hours of birth regardless of place of birth. Any special needs the client may have will be noted by the midwife (or nurse in the case of hospital births) on the postpartum referral form.

The PHN receives the postpartum referral form as advisement of birth. The PHN will contact the family within 7 days of maternal discharge or home birth and provides care as per their scope of practice. The PHN will complete the FFS and Parent Survey process as applicable, identifies client strengths and risks and determines the need and timing of public health nursing follow-up. Continuity of care will be maintained whenever possible so that the PHN providing prenatal services also provides services during the postpartum period. The PHN will follow the client as per her scope of care. PHNs providing weekends services should forward the PPRF to the appropriate CA office for follow-up.

If the midwife believes that a family could benefit from PHN support earlier in the postpartum period, for example a disadvantaged client who declined a prenatal referral to public health, she will contact the Public Health office where the client lives to connect with the assigned PHN directly. She will also note the reason for priority contact on the PPRF. Upon receiving the PPRF for a disadvantaged client, the PHN will contact the RM (if not already contacted) via the contact number on the referral and collaborate to make appropriate plans for the client. Collaboration can take many forms whereby each provider may see the client individually or together based on the needs of the client and the interest of not duplicating care. Ongoing communication between the client, the PHN and the RM may be minimal unless concerns or complexities arise.
RM role:

The RM will offer all clients a postpartum referral to public health regardless of place of birth (Appendix five – Postpartum Referral Form). The PPRF is faxed to public health central intake within 48 hours of birth if the birth takes place outside of the hospital. Any special needs of the client will be written under “Additional Discharge Notes” as well as the preferred contact information for the RM. The Postpartum Referral form is to be used by midwives to refer families to Public Health throughout the six weeks postpartum. If the client is not referred to public health immediately postpartum, the midwife is to indicate on the PPRF the reason for the delayed referral.

If the midwife believes that a family could benefit from PHN support prior to 7 days after home birth or discharge from hospital, for example a disadvantaged client who declined a prenatal referral to public health, she will contact the Public Health office where the client lives to connect with the assigned PHN directly (Appendix Seven - Public Health Community Office contact information). The reason for early contact should also be noted on the PPRF. The plan for collaborative care will be determined by the PHN and Midwife based on the needs of the client and the interest of not duplicating care.

The midwife provides primary care to the mother/newborn until they are discharged from midwifery care at approximately six weeks postpartum. The RM is available to the family by pager 24 hrs/day. RMs visit the client at least three times in the first week after delivery. As in the prenatal period, postpartum care plans will be made on a case by case basis and ongoing communication between the client, the PHN and the RM may be minimal unless concerns or complexities arise. At six weeks post-partum, RMs discharge clients. As there will be increased collaboration, the current standard discharge letter from the midwife to the PHN will be discontinued. Midwives will work with the PHN to appropriately transition care at discharge for disadvantaged clients.

4.3 Ongoing Collaboration:

Effective inter-professional collaboration will result in better access to perinatal services for disadvantaged populations, better utilization of limited resources and improved outcomes for clients. It will also result in improved working relationships and enhanced professional satisfaction.

Prenatal referrals for disadvantaged clients will increase for both public health and midwifery programs. A referral to a PHN does not replace the care of the RM, and the RM’s care does not replace the care of the PHN. The approach to inter-professional collaboration will be different based on the needs of the client.

As a client’s needs become more increasingly complex, so too does the need for inter-professional collaboration and regular inter-professional communication.
Each HCP will practice **client centered care** and in that process learn the needs and goals of the client. This information will be openly and willingly shared across providers according to the client’s wishes and PHIA. There is overlap in **roles** between PHNs and RM. Each HCP needs to know their own and each other’s scope of practice and clarify their roles. Increased knowledge of roles and communication can decrease unnecessary duplication of services. For example, because the midwife provides comprehensive care during the first week postpartum, PHN services are not generally needed nor provided until 7 days after discharge from hospital or home birth.

**Collaborative leadership** needs to take place to ensure that client’s needs are being met. A joint care plan is made with each provider taking responsibility for their roles and their standards of practice. Regular check-ins between providers and the client are recommended to verify progress and evaluate the plan of care. Where feasible, team members can meet in person ie the PHN can attend the prenatal visit at the clinic or in the home. Alternatively communication may take place via the telephone or in writing. Because PHNs and Midwives do not share a collaborative health record, all plans and communication are documented accordingly.

When communication is collaborative, responsive and respectful, the client is the kept at the center of care, and plans are clearly communicated with ongoing updates and evaluations made, relationships of trust will be established, good **team functioning** will take place and the chances of **inter-professional conflict** arising will be decreased. When conflict does arise, a focus on respectful communication and a balancing of competing values and priorities are used to help resolve the conflict.

### 5. Bibliography


6 Primary Author(s)
Darlene Girard
Kelly Klick
Gina Mount
Appendix One:  Introducing Midwifery Services to Public Health Nurse Clients

Midwifery services are available to all pregnant people. Midwives provide primary care for pregnancy, birth and for 6 weeks after birth for you and your baby. Midwives offer woman centered, trauma informed and culturally safe care that is based on informed choice and continuity of care. They are experts in low risk birth and view pregnancy as a healthy state and childbirth as a normal process.

They work with you and your family to identify your own unique physical, social and emotional needs. A midwife can provide care for your birth in hospital, at home or at the birth center, and can provide care whether or not you plan to parent. They consult and collaborate with other health care professionals if you or your baby need specialized care or additional services. Public Health Nurses and Midwives work as a team, with midwives available to you for the first six weeks after birth while Public Health Nurses may continue their work with families beyond this time frame.

If you'd like a referral I can help you with a request for midwifery services OR (if not disadvantaged) I can give you the number for the intake line (204-947-2422 ex 307). If there is availability in the midwife’s caseload she will contact you for an initial prenatal visit within two weeks and you will meet and decide together if midwifery care is appropriate for you. If there is no availability you will receive a letter in the mail declining services within 3 weeks.
Appendix Two: Introducing Public Health Services to Midwifery Clients

**Prenatal Referrals:** PHN referrals are offered to all pregnant people who are disadvantaged by social and economic circumstances and/or underserviced by mainstream health services.

PHN’s work in the community and offer family centered services that are respectful of people’s lives and circumstances. PHNs can support you to improve your health in all aspects. They focus on what you see as your strengths in your health practices and in your relationships, to assist in improving your health during pregnancy, preparing for the birth; and if you plan to, help you get ready for breastfeeding and parenting. They are familiar with resources in your neighborhood, including housing, financing and other community programs like Healthy Baby and Families First and can work with you to connect to those resources.
If you accept the referral you can expect a phone call from the PHN within the next two weeks. The PHN will work together with you and I to make a health plan according to your preferences and needs.

**Postpartum Referrals:** Postpartum referrals are offered to all families with newborns.

PHN’s work in the community and offer family centered services that are respectful of people’s lives and circumstances. As part of the follow-up plan of care for you and your baby, we offer all families a referral to Public Health. The referral form has information about your pregnancy, labor and delivery, and you and your baby, your discharge plans and current family situation. The public health nurse will provide you with information about caring for yourself and your baby and will answer any questions you have about parenting, infant care and feeding. They are familiar with resources in your neighborhood, including housing, financing and other community programs. They will work with you to connect to resources that are of interest to you. Public Health Nurses and Midwives work as a team, with midwives available to you for the first six weeks after birth while Public Health Nurses may continue their work with families beyond this time frame.

If you accept the referral, you can expect a phone call from the PHN within 7 days of discharge from hospital/home birth.
## Appendix 3: Midwifery Referral Form

**WRHA Central Intake Form**  
Midwifery Services

**Date:**  
**EMR Consent:** Yes or No

**Name (Last, First):**  
**Alternate Names/Aliases (Type):**

**PHIN:**  
**MHSC:**  
**DOB (Month/Day/Year):**

**Mailing Address:**

**City:**  
**Province:**  
**Postal Code:**

**Home Phone:**  
**Allowed to leave a message? Yes or No**

**Work Phone:**  
**Allowed to leave a message? Yes or No**

**Alternate Phone:**  
**Allowed to leave a message? Yes or No**

**Can you receive calls from a blocked number? Yes or No (if no, specify which #)**

**When was the first day of your last normal menstrual period (month/day/year)?**

**EDD (Month/Day/Year):**  
**How many pregnancies?**

**How many births?**  
**C-section? Yes or No (if yes, #)**

**During any previous pregnancies did you experience (check all that apply)?**

- [ ] Gestational Diabetes  
- [ ] Miscarriage  
- [ ] Still Birth  
- [ ] N/A

**Have you ever received midwifery care in Manitoba?** Yes or No (if yes, with)

**Have you received any prenatal care (for this pregnancy)?** Yes or No (if yes, with)

**Have you been diagnosed with (check all that apply)?**

- [ ] Diabetes  
- [ ] High Blood Pressure  
- [ ] N/A

**Do you have any language needs?** Yes or No (if yes, specify)

**Is there a partner or support person involved?** Yes or No (if yes, name/role)

**Who do you live with (check all that apply)?**

- [ ] Alone  
- [ ] Friends  
- [ ] Partner  
- [ ] With children  
- [ ] Husband  
- [ ] Family (parents, siblings, grandparents, etc.)  
- [ ] Other: 

**How many years have you lived in Canada?**

**Do you identify as aboriginal?** Yes or No (if yes, specify:  
- [ ] Metis  
- [ ] First Nations  
- [ ] Inuit)

**Have you applied for, or do you receive, financial assistance through the Healthy Baby Prenatal Benefit Program?** Yes or No

**Do you receive any type of financial assistance?** Yes or No

**Where would you prefer to give birth (check all that apply)?**

- [ ] Home  
- [ ] Hospital  
- [ ] Birth Centre  
- [ ] Uncertain

**Which WHRA midwifery sites did you want to review your intake (check all that apply)?**

- [ ] Mount Carmel Clinic  
- [ ] WHC Birth Centre  
- [ ] Access Downtown  
- [ ] Access River East  
- [ ] Access Winnipeg West

**Notes:**

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**Revised: September 18, 2013**
## Appendix Four: Prenatal Referral to Public Health

**Prenatal Referral to Public Health**

<table>
<thead>
<tr>
<th>DATE:</th>
<th>[ ] Referral discussed with client</th>
<th>CLIENT CHART #:</th>
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<tr>
<td>CLIENT Name:</td>
<td></td>
<td></td>
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<tr>
<td>Address:</td>
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<tr>
<td>Home Telephone:</td>
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<td>Work Telephone:</td>
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<td>MHS/MFRN:</td>
<td></td>
<td></td>
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<tr>
<td>PHN:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td>Gravida:</td>
<td>Para:</td>
</tr>
<tr>
<td>Language Spoken:</td>
<td></td>
<td>Expected Date of Delivery:</td>
</tr>
<tr>
<td>Interpreter Required:</td>
<td>[ ] Yes  [ ] No</td>
<td></td>
</tr>
</tbody>
</table>

**Referring Professional:** [ ] Physician  [ ] Nurse  [ ] Midwife  [ ] Social Worker

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<thead>
<tr>
<th>Name:</th>
<th>Fax #:</th>
<th>Telephone:</th>
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<tbody>
<tr>
<td>Referring Site:</td>
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**Family Physician/OB-GYN:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Telephone:</th>
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### Prenatal Referrals:

Public Health Nurses (PHNs) are offering prenatal services to all women and their families because evidence has shown that there are benefits to receiving support while they are pregnant. PHNs can provide information about:

- Prenatal education
- Parent groups
- Nutrition information
- Financial assistance
- Food banks
- Other resources

The benefits of having contact with PHNs pranataly include supporting healthy lifestyle changes. When pregnant, parents think about their use of tobacco and alcohol and are often ready to quit or reduce the amount they use in order to grow a healthier baby. A referral also includes preparing parents early for breastfeeding by reviewing the reasons for breastfeeding and how to have success. The PHNs will arrange to meet with the woman and her family in person or by phone. PHNs are available to women throughout their pregnancy and the postpartum period.

### Other Referrals Related to This Pregnancy:

(e.g., dietitian, geneticist):

- [ ]
- [ ]
- [ ]
- [ ]

### Public Health Response to Referral:

- Contact with client:  [ ] Yes  [ ] No  Date: __________
- Family First Screen:  [ ] Yes  [ ] No
- Service Plan:  [ ] PHN continued follow-up
  - [ ] Families First Home Visitor services provided
  - [ ] Referral to: __________
- Notes: __________

**PHN Name:** __________  **Phone #:** __________

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1. **Referring Site:** Fax referral with Fax Cover Sheet to Central Intake at 940-2635
2. **Public Health:** Fax completed referral with Fax Cover Sheet to referring site
Appendix Five: Postpartum Referral to Public Health
## Appendix Six: Midwifery Practice Group Office Numbers

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Access Downtown</td>
<td>204-940-3843</td>
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<tr>
<td>Access River East</td>
<td>204-938-5054</td>
</tr>
<tr>
<td>Access Winnipeg West</td>
<td>204-940-8724</td>
</tr>
<tr>
<td>Mount Carmel Clinic</td>
<td>204-9589-9412</td>
</tr>
<tr>
<td>Birth Centre</td>
<td>204-594-0900</td>
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Midwifery Central Intake:  
- (phone) 204-947-2422 ex 307  
- (fax) 204-594-0907
Appendix Seven: Public Health Community Area Contact Information

**PUBLIC HEALTH TEAM MANAGERS & ADMIN SECRETARIES**

<table>
<thead>
<tr>
<th>Community Area</th>
<th>Team Manager</th>
<th>Public Health Admin Secretary</th>
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<tbody>
<tr>
<td>Assiniboine South</td>
<td>Kim Witges</td>
<td>Barb Huisman</td>
</tr>
<tr>
<td></td>
<td>204-390-2186</td>
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</tr>
<tr>
<td>Downtown East</td>
<td>Randall Klaprat</td>
<td>Trudy Kullman</td>
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<td>Fort Garry</td>
<td>Lynne Jamault-Crocker</td>
<td>Terri Favel</td>
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<td>Inkster</td>
<td>Nancy Heinrichs</td>
<td>Shashi Sharma</td>
</tr>
<tr>
<td></td>
<td>204-226-7705</td>
<td></td>
</tr>
<tr>
<td>Point Douglas</td>
<td>Craig Ross</td>
<td>Maureen Richard</td>
</tr>
<tr>
<td></td>
<td>204-781-1076</td>
<td></td>
</tr>
<tr>
<td>River East</td>
<td>Richard Sapacz</td>
<td>Doris Woyke</td>
</tr>
<tr>
<td></td>
<td>204-612-9221</td>
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</tr>
<tr>
<td>River Heights</td>
<td>Lynne Jamault-Crocker</td>
<td>Sheryl Harron</td>
</tr>
<tr>
<td></td>
<td>204-791-7325</td>
<td></td>
</tr>
<tr>
<td>Seven Oaks</td>
<td>Emmanuel Ozokwelu</td>
<td>Janet Brenner</td>
</tr>
<tr>
<td></td>
<td>204-803-6257</td>
<td></td>
</tr>
<tr>
<td>St. Boniface</td>
<td>Joel Lafond</td>
<td>Emanuelle Arbez</td>
</tr>
<tr>
<td></td>
<td>204-771-2655</td>
<td></td>
</tr>
<tr>
<td>St. James</td>
<td>Kim Witges</td>
<td>Barb Huisman</td>
</tr>
<tr>
<td></td>
<td>204-390-2186</td>
<td></td>
</tr>
<tr>
<td>St. Vital</td>
<td>Brandy Pantel</td>
<td>Genevieve Lambert</td>
</tr>
<tr>
<td></td>
<td>204-299-9686</td>
<td></td>
</tr>
<tr>
<td>Transcona</td>
<td>Donna Jacobs</td>
<td>Shaylyn Kubin</td>
</tr>
<tr>
<td></td>
<td>204-794-5601</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix Eight: Families First Screening Form

### Screening Form 2014

- **MOTHER:**
  - Age: __________
  - PHIN: __________
  - Education: __________
  - Residence: __________

- **FATHER:**
  - Age: __________
  - PHIN: __________
  - Education: __________

- **BABY:**
  - Birth Date: __________, __________, __________
  - PHIN: __________
  - Sex: __________
  - Family background of baby: __________

### A. CHILDREN WITH KNOWN DISABILITY

<table>
<thead>
<tr>
<th>Disability Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital anomaly or acquired disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major probability of permanent disability, e.g., Down's syndrome, cerebral palsy, FASD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate (correction may be possible), e.g., cleft palate, loss of limb</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### B. DEVELOPMENTAL RISK FACTORS

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth weight (less than 2500 grams at birth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High birth weight (greater than 4000 grams at birth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prematurity – an infant born at less than 37 weeks gestation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complications of pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections that can be transmitted in utero and may damage the fetus, e.g., rubella, HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol use by mother during pregnancy, if &quot;Yes&quot;, complete section D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug use by mother during pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complications of labour and delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult vaginal birth (forceps or vacuum) or emergency caesarean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant trauma or illness (e.g., convulsions, respiratory distress syndrome)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history of a disability not detectable at birth that could affect development (e.g., deafness, mentally disabled/challenged)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple births (e.g., twins, triplets)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal smoking during pregnancy (if &quot;Yes&quot;, number of cigarettes/day: 1-20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes diagnosed before pregnancy or early in pregnancy (type 1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes diagnosed in 3rd trimester of pregnancy (Gestational Diabetes)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### C. FAMILY RISK FACTORS

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's age at birth of first child is less than 18 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother's highest level of education completed is less than grade 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On social assistance/income support or financial difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single parent family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First prenatal visit occurred at/after 28 weeks gestation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental illness or disability in mother and/or father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression (including postpartum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia or bipolar affective disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antisocial type behaviors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current substance abuse by mother or father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolonged postpartum maternal separation (5 days or more with little or no contact)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessed lack of bonding (e.g., minimal eye contact, touching)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social isolation (lack of social support and/or isolation related to culture, language or geography)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship distress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current or history of violence between parenting partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harsh and/or inappropriate discipline practices (including other children)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existing file with Child and Family Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother's own history of child abuse/neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father/parenting partner's own history of child abuse/neglect</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### D. ALCOHOL USE DURING PREGNANCY

**Warning:** Alcohol use by mother during pregnancy could be harmful to the baby.

**Guideline:** If the mother is pregnant, do not administer this test.

### Frequency

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often did mother consume alcohol?</td>
<td>Less than once a month</td>
<td>1-4 days/month</td>
</tr>
<tr>
<td>How much alcohol would she consume in one sitting?</td>
<td>1 or less</td>
<td>2 to 3 drinks</td>
</tr>
<tr>
<td>How often did bing drinking occur?</td>
<td>Less than once a month</td>
<td>1-4 days/month</td>
</tr>
</tbody>
</table>

### Once she discovered her pregnancy, how much or how often she consumed alcohol change?

- **Select one response:**
  - No
  - Yes, reduced use
  - Yes, increased use
  - Yes, stopped altogether

### Screen Completed By:

- **Name:** __________
- **Phone:** __________
- **Health Unit:** __________
- **Day:** __________
- **Month:** __________
- **Year:** __________
- **TOTAL SCORE:** __________

---

Operational Guideline for Collaborative Practice between Public Health Nurses and Midwives

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Families First Screening Form

Instructions for Completion: (see Families First Support Manual for more details)
- Please score all items yes or no. If information is unavailable, please leave item blank.
- Please print neatly in boxes and fill in circles completely using INK. — PLEASE DO NOT USE PENCIL!
- Ideally screening is initiated prenatally — if so, fill in the “Yes” circle under “Screened prenatally?”
- Screening must be finalized postnatally, to ensure completeness, before discharging (see below)

Sample Introduction: I am here today to follow-up with you and your family since the birth of baby. I will be checking to see how your baby is doing since leaving hospital (e.g. weight, feeding, how mom's recovery has been) and how the family is adjusting since the birth of baby. We will also spend some time talking about your family, the supports you have, any challenges you face and community resources that may be of interest to you. We gather the same kind of information from all families with newborns and use the information to support families in accessing resources that they may find helpful. The information we collect is recorded in a confidential health file. If you find there are some things you don't feel comfortable talking to me about, just let me know and we will move to another topic. If you have any questions or concerns throughout our visit today please let me know.

Family Background of Baby: (Collected for purposes of planning culturally safe services and directing to resources.)
First Nation, Métis, Inuit: How does family best describe their background?
Newcomer: Individuals who have migrated to Canada within the last 5 years and are in the midst of their settlement process, which is crucial for their eventual process of integration.

Francophone: Determined by exploring language preference (e.g. materials in English or French?)

B5 Infections that can be transmitted in utero and may damage the fetus
Include: rubella, HIV, toxoplasmosis, cytomegalovirus. Exclude: Hepatitis B, if child received prophylaxis; herpes, unless acquired pregnant.

B6 Ask every mother about her alcohol use throughout her pregnancy. If the mother identifies any alcohol use during pregnancy, complete section D.

B7 Drugs
Include: prescription drugs, over-the-counter drugs.
Exclude: non-teratogenic prescription drugs, small amounts of over-the-counter drugs.

B8 Infant trauma or illness (e.g., convulsions, respiratory distress syndrome) — applies to infants in the first 26 days of life or until discharge where an infant has been continuously hospitalized beyond the neonatal period.

B16 Education status of mother - if currently working at completing grade 12 or equivalency, score yes.

B17 On social assistance/income support or financial difficulties - Financial difficulties are defined as having insufficient monies available to meet basic needs after meeting financial commitments.

B18 Single parent — Answer ‘yes’ if parent identifies self as sole primary caregiver for child (include unmarried, separated, widowed, divorced, common-law relationship of less than one year).

For items C20 – C20 refer to the biological father of the baby (whether or not he is involved in parenting).

C20-C25 Knowledge of professional diagnosis. May be determined by noting medication use.

C26-C27 Does disability make learning of new information difficult?

C28-C29 Antisocial Behavior — score “yes” if 2 or more of these behaviors: unlawful behavior, repeated lying, poor work history, repeated assaults, reckless with safety, not honoring financial obligations, cannot sustain monogamous relationship for a year, history of failure to care for a child.

C34 Social isolation - Is the support enough for the mother/couple? If mother says she has no support, score item.

C35 Relationship distress – distress or conflict between parenting partners e.g. separations, frequent arguments.

Note: Screening questions related to partner violence should not be asked when both partners present.

C36, C40 Parenting partner refers to the person who the mother identifies as the secondary caregiver or parent for her children. Not necessarily the father of the baby.

C38 Score item ‘yes’ if either parent has been involved with CPS for child protection services related to a suspected or substantiated abuse/neglect of other children.

Risk Score: Total the number of points from items 1 to 38, and enter in TOTAL SCORE box. If 3 or more risk factors have been identified, the screen is positive. Proceed to complete the Parent Survey process.

Sample Conclusion: “Our prenatal and post-partum programs are delivered in partnership with Healthy Child Manitoba. The region provides service to families like yours and Healthy Child Manitoba makes sure that our services are meeting your needs — they monitor and evaluate them! In order to do this, we provide Healthy Child Manitoba with statistical information about your family and all other families. This includes general information like your age, education, alcohol use during pregnancy (brief examples to information gathered from the individual family). We do not provide Healthy Child Manitoba with your name, address or telephone number.”

Faxing the Screening Form: After finalizing this form postnatally, please FAX (reverse side only) to Healthy Child Manitoba Office (HCMO) at (204) 498-3768. (Thank you.)

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