Inter-professional Collaboration: The Virginia Baptist Story

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Objectives

Attendees will know the position and opinions of the professional organizations of midwifery and obstetrics in the United States regarding collaborative practice.
Attendees will be familiar with, and have tools to implement in their institutions, guidelines from the Homebirth Transfer Summit on the care of laboring people during transport from outside of the hospital.
Attendees will have information and resources to evaluate and improve collaboration among maternity providers in their area.

Births by the Numbers: US 2006-2016

Births by the Numbers: Virginia 2007-2016

Maternity Care Provider Access
Maternity Care Provider Access

CNMs per 100,000 population

Midwifery Integration: MISS

Source: US HRSA, US DHHS. ©Pew Charitable Trust

Higher MISS score
- Increased physiologic birth
- Less intervention
- Fewer adverse neonatal outcomes
- Correlates with density of midwives and access to care

What is Collaborative Practice?

Institute of Medicine – Crossing the Quality Chasm
- Safe
- Efficient
- Cost-effective
- Timely
- Equitable
- Patient-centered
- Institute for Healthcare Improvement - Triple Aim
- Improve experience of care
- Improve health of populations
- Lower cost

Collaborative Care is Woman-Centered

- Woman’s authority over birthing process
- Innate ability to birth
- Management revolves around client
- Increased satisfaction

From the professionals...

How do professional organizations define collaborative care?
American Medical Association

- Ethical obligation
- Team-based
- Patient-centered
- Respect and trust with effective communication
- Physician-led team
- Physician as ultimate authority
- Oppose legislation for independent practice of APRNs/midwives

American College of Nurse-Midwives

- Hallmark of Midwifery
- Collaboration with other members of interprofessional health care team
- Woman-centered in active partnership
- Standards of Practice & Core Competencies for Basic Midwifery Practice
- Care in context of family, community, and system
- Position Statement: Collaborative Management
- Independent providers
- Consultation, collaboration, and referral as indicated

National Association of Certified Professional Midwives

- Midwives Model of Care
- Woman-centered
- Respectful care – individualized and informed
- Includes identifying and referring women who require obstetrical attention

Midwives Alliance of North America

- Integrated shared care
- Cost effective
- Elevates client satisfaction
- Preferred by health care providers
- Increases accountability

ACOG Task Force on Collaborative Practice

- Full-scope practice
- Collaboration as a process
- Team-Based Care
  - At least 2 health care providers working collaboratively
  - Patient/family centered
  - Coordinated and high-quality
  - Seamless communication and transitions
  - Team members change as patient care needs and preferences change
  - Shared power in leadership

ACNM+ACOG Joint Statement 2018

- Joint statement on practice relations
- Team-based care
  - Effective communication across care settings and among clinicians
  - Collaboration of independent clinicians
- Appropriate levels of care
- Collegial relationships
  - Trust and mutual respect
  - Professional responsibility and accountability
- National uniformity in practice authority and licensure
Regulation of CNMs/CMs
Certified Midwives not currently licensed or regulated
Must have a nursing license to practice as a CNM
Joint Board of Nursing and Medicine
Licensed Nurse Practitioner
Virginia Code: Supervision to Collaboration to Consultation
Patient Care Team (2013)
Consultation (2016)

Regulation of CPMs
Board of Medicine – Midwifery Advisory Board
Licensed Midwives
Required disclosures
Restricted from carrying “controlled substances”
Immunity Clause

Joint Statement of Virginia
Virginia women want access to all maternity care providers for prenatal, labor & birth, and postpartum care. Our three organizations, the Virginia Midwives Alliance, the Virginia Affiliate of the American College of Nurse-Midwives, and the Virginia Section of the American College of Obstetricians and Gynecologists, stand committed to promoting collaborative relationships and practice environments among all providers to ensure continuity of care. These collaborative, open relationships among providers will promote quality outcomes for mothers and newborns, or, in the simplest terms, happy and healthy moms and babies.

Results from Laura’s survey
Barriers
Interpersonal
Professional judgement
Respect – provider and patient
Communication
Interdisciplinary
Safety of homebirth
Client selection
Organizational
Liability concerns
Employment and fee structures

Results from Laura’s survey
Opportunities
Increased communication and respect
Personal relationships
Sharing of common goals
Understand scope of practice
Increase autonomy of midwives (CNM and CPM)
Collaboration in Action
Virginia Baptist Hospital, Lynchburg, VA

Midwife-Physician Collaboration: CPM
Before license, there was no relationship
Transfers due to serious emergencies (actual or suspected)
Licensure and the Midwifery Advisory Board
Local meeting between 2 CPMs and local physicians and administrators
No follow-up for several years
Transport protocol established → Not implemented
In-house OB receiving transfers

Midwife Collaboration: CNMs and CPMs
Conversations, curiosity, and meetings outside of the hospital
Awareness and relationship
In-house CNM receiving transfers
Phone consults
Office referrals

How it Works Today
Communication and respect
Consultation with OB/GYN
APP policy
Hospital privileges
Admitting privileges
Covering providers in hospital
All “unassigned” FQHC contract
Billing
Hourly rate for FQHC coverage
Professional fee for US reads
OB fee for unassigned OB and CNM support
Modifier 52
Education/training
Family Medicine residents
SNM, NP & PA students

How it Really Works
OB
Joint board sign-out
Coverage of floor during surgery
Coverage during other births
Triage assistance
First assist with c/s
Second pair of skilled hands
High Risk meetings

CPM
In-office consults
Postdates testing
Facilitating processes for viK and Rhogam
Outpatient circumcisions
Hospital transfers
Receiving Transfers from Community

Communication – provider to provider
Direct admission/evaluation on L&D
CPM coming with client
Support informed consent and refusal
Postpartum and newborn care referred to CPM
Record sharing

Challenges and Opportunities

COMMUNICATION
Inclusion of CPM in care team
Debriefing and peer review
Bias (anti-physician or anti-midwife)
Primary role confusion
Secondary role confusion
Collaboration without competition
Billing
Liability

Improving Collaboration

Informal gatherings – GET TO KNOW EACH OTHER!
Education sessions/conferences
VA ACNM Annual Potpourri of Women’s Health Topics
ACOG Section Meetings
Enhancing Safety Through Maternity Care Collaboration Conference

Resources: Community Birth & Collaboration

Standard definitions/nomenclature for facilities – Birth Center through Level IV
Consistent guidelines according to level of maternal care
Proactive integration, risk-appropriate care
Best Practice Guidelines: Transfer from Planned Home Birth to Hospital
Model practice recommendations for midwives and hospital providers
Quality improvement and policy development
www.homebirthsummit.org
Smooth Transitions: Enhancing Safety of Planned Out-of-Hospital Birth Transports
D Initiative in Washington State

Improving Collaboration

Joint community education
The Motherhood Collective Panels
The Labor Comfort Measures Workshop
Peer review/group review and debriefing after transfers
Dartmouth Hitchcock Hospital Model
CONDITIONS REQUIRING IN-HOUSE TRANSFER TO OB PHYSICIAN:

- Active HSV lesions in ROM or Labor
- Cervical Cerclage
- IDDM
- HIV Positive
- IUFD - with lab abnormalities (eg: HELLP/DIC)
- Significant Fetal Anomalies – case by case (eg: hydrops, gastroschisis)
- Malpresentation – in labor or if other complications arise
- Multiple Gestation
- Complete or Partial Placenta Previa – 2nd or 3rd Trimester with bleeding
- HELLP Syndrome
- Pre-eclampsia with Severe Features AND
  - Unresponsive to labetolol or hydralazine protocol
  - Post-partum
  - Eclampsia
  - Preterm
- Previous c/s with classical scar or T-incision
- Chronic or suspected abruption <36 weeks
- Uterine infection - not responding in typical course
- PPROM - <32 wks
- Preterm Labor - < 32 wks delivery not imminent
- Pyelonephritis - not responding in 48 hours or abnormal VS
- Maternal cardiac defect – with MFM recommendation to deliver at transfer center
- Suspected Ectopic