

Inter-professional Collaboration: The Virginia Baptist Story

Katie Page, CNM

In Collaboration with Wade Neiman, MD and Leslie Payne, CPM

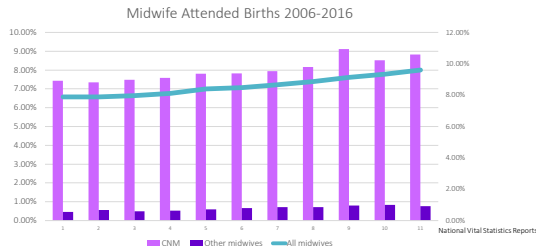
Objectives

Attendees will know the position and opinions of the professional organizations of midwifery and obstetrics in the United States regarding collaborative practice.

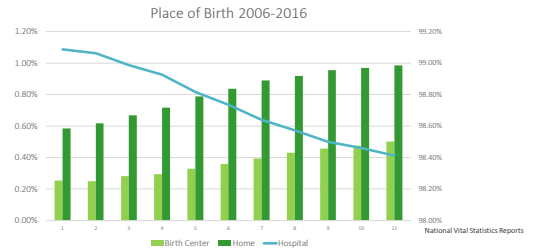
Attendees will be familiar with, and have tools to implement in their institutions, guidelines from the Homebirth Transfer Summit on the care of laboring people during transport from outside of the hospital.

Attendees will have information and resources to evaluate and improve collaboration among maternity providers in their area.

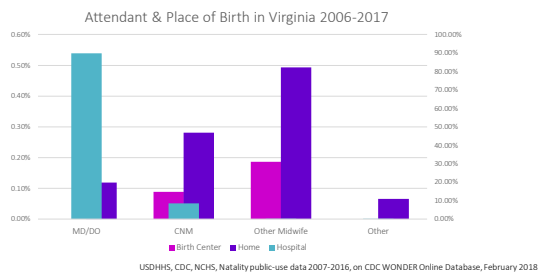
Births by the Numbers: US 2006-2016



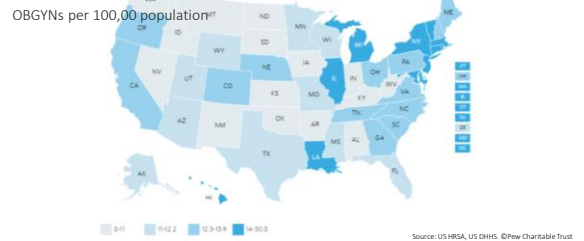
Births by the Numbers: US 2006-2016



Births by the Numbers: Virginia 2007-2016

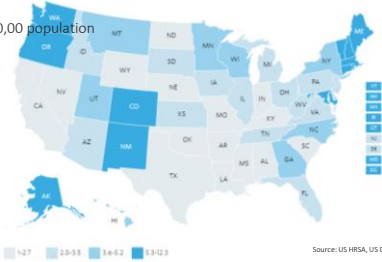


Maternity Care Provider Access



Maternity Care Provider Access

CNMs per 100,000 population

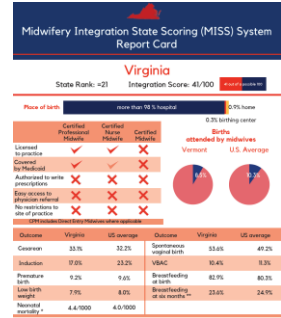


Midwifery Integration: MISS

www.birthplacelab.org

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

Vedam S, et al. PLOS ONE, 2018;13(2):e0192523



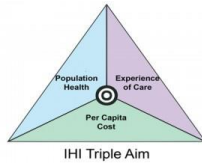
What is Collaborative Practice?

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

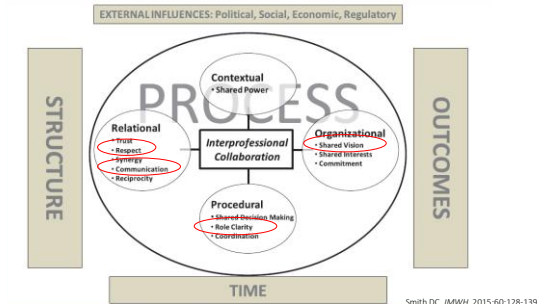


Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century, 2011.

Collaborative Care is Woman-Centered

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

Bailes A, Jackson ME. JMWJ, 2000; 45:537-43.



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*
 - Shared decision-making
- 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

ACOG Task Force on Collaborative Practice. *Obstet Gynecol*. 2016;127(3):412-417.

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

Collaboration in Action

Virginia

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

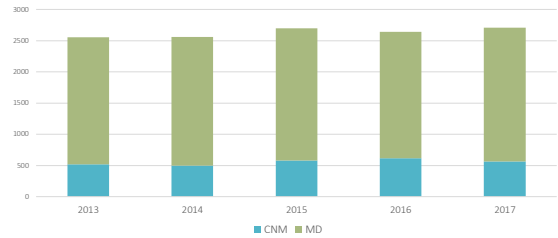
Results from Laura’s survey

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

Births at the Baptist



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

- | | |
|--|---|
| <ul style="list-style-type: none"> Communication and respect Consultation with OBGYN <ul style="list-style-type: none"> APP policy Hospital privileges Admitting privileges Covering providers in hospital <ul style="list-style-type: none"> All "unassigned" FQHC contract | <ul style="list-style-type: none"> Billing <ul style="list-style-type: none"> Hourly rate for FQHC coverage Professional fee for US reads OB fee for unassigned GYN and CNM support Modifier 52 Education/training <ul style="list-style-type: none"> Family Medicine residents SNM, NP & PA students |
|--|---|

How it Really Works

- | | |
|---|---|
| <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> CPM In-office consults Postdates testing Facilitating processes for vitK and Rhogam Outpatient circumcisions Hospital transfers |
|---|---|

CONDITIONS REQUIRING IN-HOUSE TRANSFER TO OB PHYSICIAN:

- Active HSV lesions in ROM or Labor
- Cervical Cerclage
- IODM
- HIV Positive
- IUFD - with lab abnormalities (eg: HELLP/DIC)
- Significant Fetal Anomalies – case by case (eg: hydropi, 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 labetalol or hydralazine protocol
 - Post-partum
 - Eclampsia
 - Preterm
- Previous US with classical scar or T-incision
- Chronic or suspected abruption <36 weeks
- Uterine infection - not responding in typical course
- PPRM - <32 wks
- Preterm Labor - < 32 wks delivery not imminent
- Pyelonephritis - not responding in 48 hours or abnormal US
- Maternal cardiac defect – with MFM recommendation to deliver at transfer center
- Suspected Ectopic

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



Home Birth Summit. Best Practice Guidelines: Transfer from Planned Homebirth.

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

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

Resources: Community Birth & Collaboration

ACOG/SMFM Levels of Maternal Care, *Am J Obstet Gynecol*, 2014.
 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

QI Initiative in Washington State - <http://www.washingtonmidwives.org/documents/Smooth-Transitions-Hospital-Transport-QI-Project.pdf>

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