

Sharing Maternity Care

Access to maternity care is a public health concern in many rural areas. Sharing care among physicians and other health care providers is one solution.

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Early and regular prenatal care has been shown to improve perinatal outcomes.^{1,2} However, women living in rural areas and smaller communities often have difficulty accessing maternity care because they reside in places that generally can't support an obstetrician or a hospital with a labor and delivery suite. Instead they must travel to larger regional medical centers and, as a result, often delay seeking prenatal care or are seen less frequently during their pregnancies.

Most women choose shared care, preferring consistent prenatal, postpartum and newborn care.

One answer to improving access for these women is the "shared care" maternity care management model. This model divides perinatal and postpartum care among two or more health care professionals.

Although there are many ways to share care, one of the most common arrangements is for a family physician in the local community to provide prenatal care and another health care professional (usually an obstetrician/gynecologist) to see the mother periodically during her pregnancy (usually early in the second trimester and for two to three visits close to term) and deliver the child. With this model, the patient continues her relationship with her local physician while establishing a relationship with the obstetrician prior to delivery. Shared care not only improves access to prenatal care, it enhances compliance and encourages continuity of care.¹

Improved care, satisfied patients

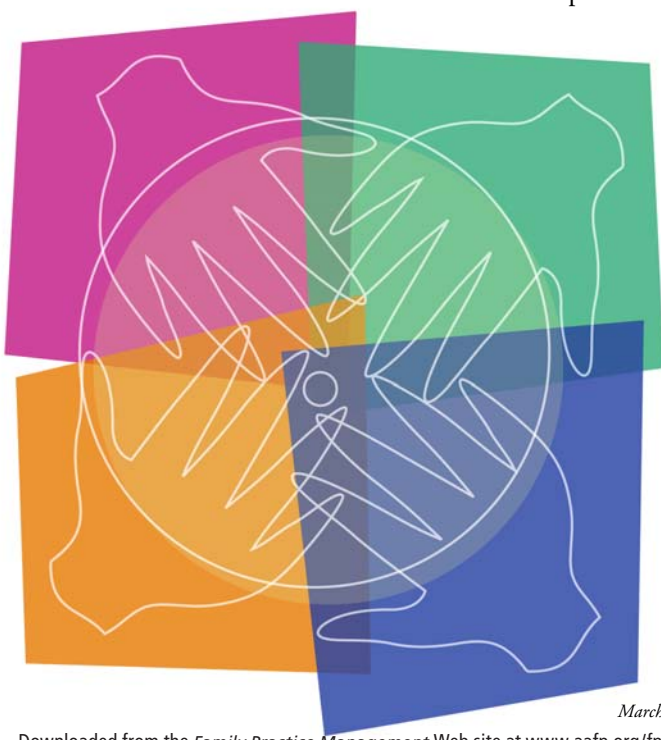
A shared-care protocol developed by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) appears on page 39. Dr. Boyle's practice, Carilion Family Practice, has adapted and used this protocol in shared-care arrangements with several obstetric and gynecologic offices for the past few years. Once a pregnancy is confirmed, each patient is given the option of being referred to the physician of

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ILLUSTRATION BY C. M. SCHNEIDER



Shared care allows a pregnant patient to continue seeing her local physician while establishing a relationship with the delivering physician prior to delivery.

Physicians using shared care should follow a protocol, such as the one developed by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

Women participating in shared care meet their delivering physicians for the first time during a prenatal visit at 18 to 22 weeks gestation.

Another visit is routinely scheduled during the third trimester, if the pregnancy exceeds 40 weeks duration or more often, if needed.

her choice or participating in shared care. Most choose shared care, preferring to have consistent prenatal, postpartum and newborn care. Women meet their delivering doctors for the first time during an antepartum office visit at 18 to 22 weeks gestation. The practice has found that timing the ultrasound to occur as part of this initial visit strengthens the rapport between the patient and physician. Another visit is scheduled during the third trimester or if the pregnancy exceeds 40 weeks gestation.

To facilitate the exchange of patient information between offices, locations within the Carilion Health System use an electronic version of the prenatal chart documentation forms from the AAFP Management of Maternity Care program (www.aafp.org/momcare.xml). Another location is part of a separate hospital system and uses a paper-based version of the prenatal care forms that appear in *Guidelines for Perinatal Care*, jointly published by the AAP and ACOG and available through their bookstores at www.aap.org and www.acog.org.

Since August 1999, 16 patients in Dr. Boyle's practice have participated in shared care. Only one patient transferred her care to an obstetrician after initially choosing shared care. One patient miscarried at 24 weeks. All others have successfully delivered or are currently awaiting delivery. One mother is in her second shared-care pregnancy. Others have referred friends to the practice for pre-

LIABILITY CONCERNS

Malpractice insurance carriers categorize the majority of family physicians who do not practice obstetrics as Class 1 and those who do as up to a Class 4 (obstetricians are usually a Class 8). Premiums increase with each class. These are perhaps the only generalizations that can be made, given the upheaval in the malpractice liability market at this time. When Ginger Boyle, MD, began practicing shared care several years ago, companies were willing to review each physician individually, but they differed as to whether to let these physicians remain a Class 1 or increase their risk to Class 2, 3 or 4. Several insurance companies expressed concern about the risk of intrapartum or neonatal complications. When speaking with malpractice insurance carriers, Dr. Boyle recommends that family physicians define their role in the patient's care, emphasize that they are providing prenatal care and are not actually performing deliveries, describe their collaboration with the delivering physician and review studies reporting improved patient outcomes and lower incidence of malpractice lawsuits for physicians providing shared care. By doing this, Dr. Boyle remained a Class 1 liability risk.

KEY POINTS

- By sharing prenatal responsibilities, family physicians can care for their pregnant patients without the lifestyle hassles and malpractice risks associated with delivery.
- Shared care facilitates early and regular prenatal care for pregnant women in rural areas who may otherwise have difficulty accessing care.
- Other benefits include improved continuity of care, increased patient satisfaction and more favorable perinatal outcomes.

natal care or have said they will use shared care for subsequent pregnancies. Overall, the women have expressed a high degree of satisfaction with shared care and with having their local physician provide as much care as possible.

In a different shared-care arrangement, a rural regional referral hospital in Morehead, Ky., used nurse midwives and family physicians as the primary medical care providers and obstetricians for back-up support. Patients received prenatal care at one of the clinics and were then referred to the medical center for delivery. Nurse midwives cared for most low-risk patients; family physicians assumed responsibility for complicated pregnancies or instrument-assisted deliveries; and obstetricians were consulted for surgical deliveries. During the time the program operated, deliveries to women without prenatal care decreased and more women received prenatal care earlier in their pregnancies.² Shared care also has been shown to reduce non-labor maternity care admissions and length of stay.³

Satisfied physicians

Physicians who've participated in shared care say the key is proper communication and exchange of information. Proper communication with patients involves fully explaining shared care, including the role of the delivering physician and the details described in the protocol. Communication with the delivering physician requires coordination of prenatal forms as well as exchange of lab and office visit data (especially after the initial OB work-up and

the 15- and 28-week labs). Family physicians interested in developing shared care should start by proposing the arrangement to their patients' obstetricians or delivering physicians.

Perceptions and reality

Although most women believe that their family physician can provide competent perinatal care, according to the AAFP, only 28 percent of family practices include obstetrics. In fact, the percentage of family physicians in the United States who deliver babies has

declined steadily in the last 20 years. Reasons include perceptions about malpractice risk, attitudes of obstetricians and impact on physicians' lifestyle and income.⁴

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In Dr. Boyle's case, perception was far from reality. The malpractice risk she assumed was not insurmountable and once she familiarized her insurance carrier with her

shared-care arrangement, her claims have been processed without difficulty (see the box on page 40 for a list of commonly used codes). The obstetricians in her region

SHARED CARE PROTOCOL

The primary care physician or other health care provider is responsible for the visits below, as well as for appropriate follow-up unless otherwise indicated. Additional visits with the primary care physician may be required in the first trimester and after the ultrasound, depending on the needs of the patient. Office visits with the delivering physician should be scheduled at 18 to 20 weeks, during the third trimester and after 40 weeks if the patient has not yet delivered.

4-8 weeks

- Perform initial obstetric work-up.
- Assess need for early referral to delivering physician.
- Discuss appropriate frequency of visits with the patient.

12-16 weeks

- Draw triple screen (including expanded maternal serum alpha-fetoprotein) blood test (document if declined).
- Send copy of all labs to delivering physician.

16-20 weeks

- Consider scheduling ultrasound and initial visit at delivering physician's office, if possible. If not, schedule initial visit with delivering physician after ultrasound. Send copy of results to delivering physician.

24-28 weeks

- Draw 28-week labs (Hgb/Hct, RPR for syphilis, antibody screen, 50-gram glucose screen).
- Send copy of results to delivering physician.

32-36 weeks

- Consider performing group B strep culture at 34 to 36 weeks.
- Send copy of results to delivering physician.
- Schedule one of these appointments with delivering physician, if requested by patient or delivering physician.

36-40 weeks

- Schedule appointment with delivering physician near term, or if fetal monitoring is needed but cannot be provided at primary care physician's office.

40 weeks +

- Schedule appointments with delivering physician.

Adapted with permission from American Academy of Pediatrics and American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*. 5th edition. Elk Grove Village, Ill: American Academy of Pediatrics; 2002; and Washington, DC: American College of Obstetricians and Gynecologists; 2002.

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One of the authors, Dr. Boyle, adapted the shared-care protocol developed by ACOG and AAP for use in her practice.



Overall, patients have been highly satisfied with shared care and with having their local physicians provide much of their care.



Physicians who've participated in shared care say the key is proper communication and exchange of information.



Communication with the delivering physician requires coordination of prenatal forms as well as exchange of lab and office visit data.

Family practices that include obstetric care have decreased steadily in the past 20 years.

However, several studies have shown that physicians who do OB experience increases in income, professional satisfaction and practice diversity.

It is reasonable to expect that physicians who provide prenatal care in a shared-care program would enjoy similar benefits.

Making shared care a reality includes partnering with other physicians and providers as well as insurance plans and liability carriers.

understand the difficulties of her rural population and have been appreciative of the extra referrals.

Several studies also point to the potential advantages of shared care. For example, in a secondary analysis of a Florida study comparing primary care physicians who practiced obstetrics with those who didn't, responses from physicians who provided prenatal care but did not do deliveries were separated out as the shared-care group. This group and the group of physicians delivering babies had similar responses. Both groups reported increases in income, professional satisfaction, practice diversity, numbers of complete families in the practice and reduced malpractice risk when compared with the group that did not provide obstetric care.⁵

In another study, physicians cited the following reasons for including obstetrics in their practices: enjoyment (92 percent), desire to care for younger patients (78 percent), adequate training in residency (77 percent), able to obtain privileges (67 percent), supportive practice (63 percent), acceptable lifestyle (51 percent), community

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obstetricians supportive (42 percent), affordable malpractice insurance (31 percent), adequate reimbursement (31 percent) and minimal fear of lawsuit (17 percent). It is reasonable then to expect that physicians who provide prenatal care in a shared-care program would enjoy similar benefits and satisfaction.⁴

Collaboration is key

Improving perinatal outcomes and access to

COMMONLY USED CPT CODES FOR MATERNITY CARE

Service provided	CPT code
Routine obstetric care including antepartum care, vaginal delivery and postpartum care	59400
Antepartum care (1-3 visits); use appropriate level for each visit	99201-99215
Antepartum care only (4-6 visits); includes the "new OB visit"	59425
Antepartum care only (7 or more visits); includes the "initial OB visit"	59426
Postpartum care only	59430
Vaginal delivery only (with or without episiotomy and/or forceps)	59409
Vaginal delivery; including postpartum care	59410
Cesarean delivery only	59514
Cesarean delivery only; including postpartum care	59515

Source: CPT 2003. Professional ed. Chicago: American Medical Association; 2002.

obstetrical care in underserved areas has been given high priority in many states, including Virginia, Florida and Kentucky. Given that the most significant factors for improving outcomes are early and regular prenatal care, and that a lack of easy access to such care is most often the determining factor for delay or noncompliance, shared care provides a viable solution. Making shared care a reality requires partnering with other providers, insurance plans and liability carriers. This is admittedly not an easy task, but it can be rewarding for family physicians seeking to serve and improve the lives of their patients. **FPM**

Send comments to fpmedit@aafp.org.

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