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Shared Maternity Care and Credentialing

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What is Shared Maternity Care?

- Antenatal Care shared between an accredited general practitioner or midwife in the community and a hospital
- For patients identified as low risk – exclusion criteria for women clearly stated in Shared Care Guidelines

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Background

- Shared Maternity Care introduced in 1988 at MHW
- Communal criteria across three centres commenced in 2002
  - MHW, RWH & Sunshine
- Why?
- Shared Maternity Care Affiliates ~ 700

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Credentialing

- Criteria determined by meeting(s) between Clinical Directors of each facility, GPLOs, representatives from JCCO & RACGP
- Accredit at any time
- Re accredit every 3 years (in line with RACGP QA&CPD triennium)

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Accreditation Requirements

Accreditation as a SMCA:

- Medical Board Victoria registration
- Current medical indemnity
- DRANZCOG within last 5 years
- Dip Obstetrics or DRANZCOG prior to 2001 with ongoing affiliation with hospitals providing shared antenatal care
- Appropriate recent experience in obstetric care as agreed with representatives from the 3 centres
- Commitment to the guidelines and other criteria

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Re accreditation Requirements

Re accreditation as a SMCA:

- Medical Board Victoria registration
- Current medical indemnity
- Demonstrate ongoing education in ***pregnancy related care:*** 10 RACGP QA&CPD points
- ***Pregnancy related care*** not a separate category within RACGP – requires assessment and interpretation as to what fulfils pregnancy related under the women's health umbrella

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Process

- Defining the criteria – time management issues re meetings to achieve this
- Administration complex, costly & time consuming
  - **Large resource drain**
  - **Consistent forms & administration across sites**
  - **Communication between sites**
  - **Consistent notification to GPs**
  - **Confusion with DRANZCOG requirements**
- Educational activities must be offered
  - Cost of RACGP Providers Package, staff & materials

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Process

Time Line

2002	~ June – Establish criteria
2003	June – Start advertising criteria
2004	May/June – Mail out re accreditation forms Oct – Forms due (may submit to any site) Nov – Start processing applications. Successful applicants sent certificate and *survey A.*
2005	March – Close off re accreditation. Non responders & those choosing not to re accredit sent letter & *survey B* Nov – Review & set criteria for 08-10 triennium
2006	June – Start advertising criteria
2007	May – Mail out re accreditation forms Oct – Forms due (may submit to any site) Nov – Start processing applications. Successful applicants sent certificate and *survey A.*

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Re accreditation Feedback Survey A

GPs who re accredited:

Q1 *I thought the criteria for reaccreditation were:*

very unreasonable → very reasonable

	1	2	3	4	5
(n=226)	1%	3%	7%	39%	49%

Q2 *I thought the process for reaccreditation was:*

very hard → very easy

	1	2	3	4	5
(n=219)	1%	5%	26%	36%	31%

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Re accreditation Feedback

GPs who re accredited – general comments:

- ‘Saturday option very good option and enjoyable’
- ‘Saturday option as automatic for reaccreditation great improvement, excellent/valuable, worthwhile
- ‘Lecture series informative and great’
- ‘No problems’

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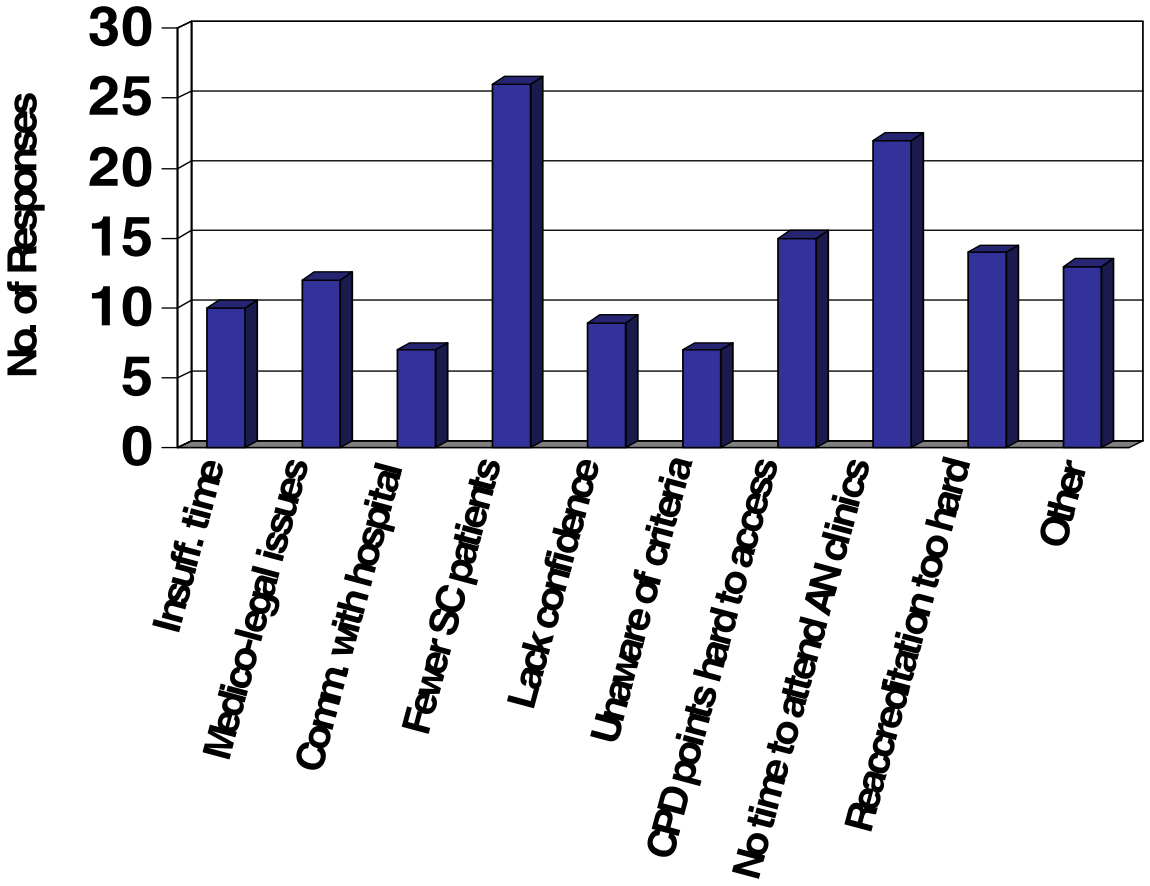
Re accreditation Feedback Survey B

Why some GPs chose not to re accredit:



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Re accreditation Feedback

Why some GPs chose not to re accredit:

- Personal
- No longer taking obstetric patients
- 90% of patients go private
- Insufficient time for educational activities
- Practice too far from hospitals (Geelong, Sorrento, Numurkah, Hampton Park)
- Did not receive forms
- No need to prove his medical competence. Disgusted with process!

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Assessment of Communications

Shared Maternity Care: All Care – Not Enough Responsibility?

An audit of patient care communications pre- and post a multi faceted intervention.

Susan Nicolson, Marie Pirotta, Patty Chondros

RANZCOG Dec 2005

- 150 hospital records

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Assessment of Communications

Conclusions

- Standards of integration are low
- Hospital commitment to provide resources
- Highlighted the importance of there being ***one role defined and responsible for coordination of communications*** in antenatal shared care in the outpatient department

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Issues to Consider for the future

- **For the patient**
  - Does credentialing improve outcomes for SMC patients?
  - Quality assurance for patients
  - Patient perception improved with credentialing?
  - Increasing sub specialisation of general practice with loss of providers available in the community

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Issues to Consider for the future

- **For the GP/SMCA**
  - Is it too onerous for GPs?
    - Adequacy of undergraduate training
    - Consensus re state wide criteria and reduced red tape with one body to oversea
    - Confusion with RANZCOG
    - DRANZCOG only
  - Recognition and management of international medical graduates and qualifications?

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Issues to Consider for the future

- **For the Institutions**
  - Is it cost effective?
  - Loss of experienced GPs to the system reduces a resource that significantly supports hospital function
  - Increasingly midwifery driven care and it's implications
  - Demonstrates efforts to improve medical standards and quality of care