# Shared antenatal care

## *A regional perspective*

**BACKGROUND** Since the early 1990s in Australia there has been a shift from private to public obstetric care, resulting from a number of factors including falling private health insurance rates and a decrease in the number of general practitioners undertaking obstetric care. Strategies were required to address the overload in the public hospital obstetric system, and increase the number of skilled practitioners involved in obstetric care.
**OBJECTIVE** This article aims to outline the process and delivery of a system of shared care in obstetrics developed by the Geelong Division of General Practice in conjunction with Barwon Health, midwives and obstetricians.
**DISCUSSION** The shared antenatal care program, established in 1994, aims to develop and encourage standardised antenatal and postnatal protocols and provide high standards of obstetric care. The program has evolved in response to new challenges and has brought benefits in improved continuity and coordination of obstetric care, fully utilising established therapeutic relationships, rationalising resources, upskilling medical staff and promoting linkages between obstetricians, midwives and GPs.

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Geelong, Victoria's second largest city, is located on the shores of Corio Bay some 75 km southwest of Melbourne. It is the leading industrial centre for the state's southwest with a population of 190 000. The General Practitioner Association of Geelong (Geelong division) has a membership of 205 general practitioners in 61 distinct practices, of which 16 are in Rural, Remote and Metropolitan Areas (RRMA) 4–5 locations. Barwon Health is the health network of the Barwon region of the Victorian Department of Human Services (DHS) Barwon South Western Region, which provides acute and community services to the Geelong area. The major public hospital is the Geelong Hospital, where public obstetric care occurs.

The Geelong Division of General Practice began its shared care program in obstetrics in 1994. This program was developed at a time when there was a shift from private to public obstetrics with falling private health insurance rates and a decrease in the number of GPs providing private obstetric care. The public hospital obstetric system was overloaded with patients, and more skilled practitioners were required to service the increased number of public obstetric patients. The project sought to achieve the upskilling and education of more GPs in antenatal care, while providing a structure for accreditation and the maintenance of high standards of obstetric practice.

The Department of Health and Aged Care funded the program initially by special project application and later as part of the Divisions Block Grant Funding allocation.

## The Geelong division shared antenatal care program

The shared antenatal care program was developed collaboratively by GPs, midwives and obstetricians in order to provide high standards of care and to further develop and encourage the use of standardised antenatal and postnatal protocols. The program has evolved in response to new challenges, including the availability of services such as genetic counselling, and changes to the timing and number of visits as recommended in the Three Centres Consensus Guidelines on Antenatal Care.[1]

### Selection of patients for shared care

All pregnant women booking for delivery at Barwon Health are assessed for suitability for shared antenatal care. These options include shared antenatal care between the hospital outpatients and

| No. of visits | Weeks pregnant | ROUTINE ASSESSMENT AND TESTING |
|---|---|---|
| | Initial | **General practitioner**<br>• confirm pregnancy<br>• order routine antenatal screening tests **(see below Copy to ANC)**<br>• QUIT literature as indicated<br>• antenatal referral<br>• early referral to ANC for genetic counselling **(if required)** |
| 1 | 8–12 | **Outpatients department – antenatal clinic**<br>✓ booking in with midwife including booking for childbirth education classes<br>✓ assessment with consultant/registrar<br>✓ routine antenatal screening tests **(checked)**<br>✓ QUIT counselling and literature as indicated<br>✓ genetic information (given) and/or test ordered – maternal serum screening at 15 weeks<br>✓ request slip for ultrasound for 18-19 weeks |
| 2 | 16 | **General practitioner or midwife**<br>✓ routine assessment<br>✓ check routine 18-19 weeks ultrasound ordered<br>✓ follow up results of genetic testing<br>✓ follow up QUIT counselling |
| 3 | 20 | **General practitioner or midwife**<br>✓ routine assessment<br>✓ follow up 18-19 week ultrasound results<br>✓ note fetal movements<br>✓ encourage childbirth education classes |
| 4 | 26 | **General practitioner or midwife**<br>✓ routine assessment<br>✓ order routine 28 weeks pathology |
| 5 | 30 | **General practitioner or midwife**<br>✓ routine assessment<br>✓ follow up pathology results |
| | | **ANTENATAL CLINIC – if previous C/S for pre-admission and mode of delivery** |
| 6 | 33 | **General practitioner or midwife**<br>✓ routine assessment |
| 7 | 36 | **Outpatients department – antenatal clinic**<br>✓ routine assessment<br>✓ order GBS swabs. *If required order: Rh antibodies (NEG. blood group), repeat Hb<br>✓ pre-admission/discharge planning – midwife |
| 8 | 38 | **General practitioner or midwife**<br>✓ routine assessment<br>✓ follow up pathology results |
| 9 | 40 | **General practitioner or midwife**<br>✓ routine assessment |
| 10 | 41 | **Outpatients department – antenatal clinic**<br>✓ assessment with consultant |

**Figure 1. Shared antenatal care protocol**

| ROUTINE ANTENATAL SCREENING TESTS | |
|---|---|
| **Initial** | Blood group, Rh antibodies, FBE, rubella, hep B, hep C, RPR, Pap smear, varicella, HIV, MSU |
| **15 weeks** | **Maternal serum screening test** |
| **18–20 weeks** | **Ultrasound** |
| **28 weeks** | GCT, FBE, Rh antibodies if negative |
| **36 weeks** | GBS swabs, Rh antibodies if negative, repeat Hb |

GCT = Glucose Challenge Test
GBS = Group B streptococcus

**Figure 1. Shared antenatal care protocol (continued)**

the GP, midwife, or family birthing unit midwife or consultant only care (in high risk pregnancies). The decision to enter shared antenatal care is a joint decision made by the woman, her GP and the obstetrician, all of whom share responsibility.

### Requirements for GPs to participate in shared care

The patients are considered public hospital patients; hence the GP is required to be credentialed by the Barwon Health Credentials Committee. The GP is expected to apply, outlining previous experience and qualifications. The committee grants privileges for either three years (those with obstetric experience or DRANZCOG), or for one year conditional upon undertaking a 10 week term in the antenatal clinic under the supervision of a consultant.

#### Clinical rotations through the antenatal clinic

There are two positions every 10 weeks for GPs in the antenatal clinics, with five rotations per annum giving 10 GPs an opportunity each year to update skills. Clinics are once per week and GPs are paid a modest amount to cover practice costs.

#### Continuing professional development

Each GP who participates in shared care is expected to attend, along with midwives and consultants, an annual antenatal educational meeting, co-hosted by the division of general practice and Barwon Health Women's and Children's Health Unit. The division also provides educational meetings on antenatal and postnatal care, including postnatal depression.

### Patient held antenatal record

The patient held record was designed to aid communication between the GP, patient, and hospital clinic staff. It aids in the early identification of risk factors and ensures that necessary tests are carried out as per the standard protocol. Patients are encouraged to examine and ask about entries in the record, and often keep the record as a further memento of the pregnancy.

### Protocols for GPs

Consultation with the RACOG and consultants has led to the latest protocol (Figure 1) although this is currently in the process of another revision. The tests are performed at the rebate fee through the local pathology company and hospital medical imaging group. The Three Centres Consensus Guidelines on Antenatal Care[1] provided a consensus statement on some aspects of clinical care for low risk women based on the best available evidence. These guidelines will be used as a template for collaborative revision of shared maternity care at Barwon Health. The DHS has further collaboratively developed process guidelines for the provision of shared maternity care between hospitals, GPs and midwives.

## Process of care

On diagnosis of pregnancy, the patient's family, medical and obstetric history is documented on the patient held Pregnancy Health Record. General practitioners are requested to complete an antenatal referral sheet (Figure 2) which is faxed to the clinic. This form has been adapted for Medical Director computerised medical record system and in the future may be sent by encrypted email.

Referrals are triaged by staff for both category of risk and urgency. Waiting times are approximately 2–3 weeks for routine cases. Women are invited to attend any of the antenatal clinics unless the pregnancy falls into a particular risk group such as multiple pregnancy, chemical dependency, dia-

**REFERRING DOCTOR DETAILS:** **PATIENT DETAILS: (sticker)**

Name:
Address:
Phone number:
Fax: Maiden name or alias: DOB:

Aboriginal or Torres Strait Islander? Mother [_] Baby [_]
Language: Interpreter required YES [_] NO [_]
Next of kin or contact person:
Surname: First name:
Address: Phone: Mobile:

REFERRAL DETAILS:
GRAVIDA: PARITY: LNMP: EDD:

**KNOWN RISK FACTORS: (please give details)**

**Previous obstetric history:**

**Medical Hx:**

**Genetic Hx**: Genetic counselling required?:

Smoking: Alcohol: Recreational drug use:

**MEDICATIONS:**

Nonprescribed medications?

**Preferred clinic** (circle)
TUESDAY AM TUESDAY PM FRIDAY AM FRIDAY PM

**PATHOLOGY ORDERED:** (copies to ANC)

| | | | | | |
|---|---|---|---|---|---|
| Blood Group | [_] | Hep B | [_] | **ULTRASOUND** (copies to ANC) | |
| Antibody status | [_] | Hep C | [_] | Location: | |
| FBE | [_] | RPR | [_] | **LAST PAP SMEAR** | Year |
| Rubella status: | [_] | HIV: | [_] | Results: | |
| MSU: | [_] | | | Location: | |

I am willing to participate in shared antenatal care if indicated: Yes [_] No [_]

Signature: _____ Date:

**Figure 2. Request for antenatal outpatient appointment**

Shared antenatal care means that during the pregnancy you can visit both the hospital and your local family doctor or a midwife. Together, they will 'share your care'.

**You can:**

- **Usually see the same care provider throughout the pregnancy**
- **See that care provider at a location that is near to you**
- **Establish ongoing community care for both yourself and your baby.**

If you choose to participate in shared antenatal care with your local general practitioner, your GP may charge some fees. This amount varies among doctors. Please discuss any questions regarding this with your chosen doctor.

Barwon Health Women's and Children's services also runs midwifery clinics, please enquire at the antenatal clinic for a midwifery service near you.

On completion of your antenatal clinic visit you will be allocated to shared antenatal care, and you will be given your pregnancy record to carry to each visit with health professionals.

**Please bring this with you to all visits during your pregnancy and when you come in to have your baby. This will ensure that your details and information are accurate and up to date.**

You may choose to stop shared antenatal care at any time during your pregnancy by contacting the antenatal clinic.

If you develop problems during your pregnancy, shared antenatal care may not be suitable and your care may revert back to the antenatal clinic.

For information and appointments contact the outpatients department or contact your GP.

**Figure 3. Information for patients**

**Table 1. Exclusion list for shared care**

Pre-existing maternal disease:

- Cardiovascular
  - established heart disease, pulmonary embolism or DVT, chronic hypertension requiring treatment
- Urinary system
  - established renal disease
- Psychoneurological
  - established mental disorder adjudged by medical professionals to be at risk psychologically
- Endocrine
  - diabetes mellitus, unstable gestational diabetes, thyroid disease requiring medication
- Respiratory
  - acute asthmatic condition, major respiratory disorders
- Other systems
  - active malignancy, haemolytic disease, proven syphilis
- Maternal physical findings
  - multiple pregnancy
- Abnormal conditions developing during pregnancy

betes, multiple miscarriage and other associated problems. Exclusion criteria for standard care are listed in Table 1. The admitting midwife is the first contact at the hospital for the patient.

Patients electing to share care with their usual GP are given an information sheet (Figure 3). General practitioners are provided with the protocol sheet (Figure 1). In the case of need for urgent consultation, the GP contacts the obstetric registrar or the consultant.

Screening conducted during pregnancy includes routine screening for risk factors associated with postnatal depression (PND). It is known that 10–20% of women suffer from clinical depression following childbirth[2] making PND a very common adverse outcome of pregnancy. Depression in the postpartum period gives rise to personal distress and often disharmony between partners and may interfere with the woman's perception of her child. The national goals, targets and strategies for improving mental health seeks to reduce the prevalence of PND in women who have recently given birth by 20%.[3] Screening is carried out early in pregnancy and at 28 weeks gestation using the Edinburgh Postnatal Depression Scale (see page 122 of this issue).[4] Education in management of postnatal depression is available from the division of general practice.

## Postnatal care

Early hospital discharge of mother and baby before 72 hours has extended the continuum of care between hospital and community. A neonatal examination is conducted before discharge at 24–72 hours of age. Neonates discharged before 72 hours are examined by their GP between days 5–10 to exclude congenital heart disease, dislocation of the hip, cataract, cleft of the soft palate and abdominal visceromegaly. This also provides the opportunity to discuss the pregnancy outcome with the mother and assess feeding, maternal supports and adjustment, and mood. Discharge summaries are faxed to GPs within 24 hours of discharge. With the development of encryption processes, it is expected that

**Table 2. Benefits of a shared antenatal care program**

**Patient benefits**

- care in the setting of an established therapeutic relationship
- community based care in the GP's surgery
- holistic care
- more convenient consultation times
- less waiting in hospital clinics
- less travelling time and expense
- improved continuity and coordination of care

**Hospital benefits**

- resources rationalisation
- financial (a reduction in the number of antenatal hospital visits for women with normal pregnancies)
- human resources (obstetric staff able to devote more time to high risk pregnancies)
- extra GPs doing antenatal clinical rotations in antenatal clinics
- enhanced of relationships between specialist and resident staff and local GPs

**GP benefits**

- continuity of care and promotion of linkages with specialist and hospital resident staff and midwives
- improved opportunities to provide total patient care, including postnatal care
- participation in obstetric services
- access to continuing professional development in antenatal care

these summaries will be sent by email.

## Benefits, problems and challenges

The benefits of the program are outlined in Table 2. Some problems seen have related to the coordination of GPs, the reluctance of some GPs to embrace changes in obstetric care and the challenge of developing protocols and referral forms to suit the varied opinions of GPs, midwives and obstetricians. There have been a number of changes to the protocols and some would say they are prescriptive; others have suggested that having the GP order the antenatal pathology and ultrasounds amounts to state-federal cost shifting.

Timely receipt of discharge summaries by GPs is being dealt with under the Effective Discharge Project of Barwon Health.

The move toward midwife-led antenatal care has been a challenge, with some resentment by GPs of what has traditionally been a general practice role. The clinic 'admission' role of the midwife may lead to a bias in the type of shared care that is undertaken. Barwon Health have set up outreach clinics in several of their community health service rooms to enable some patients to be seen nearer to their homes. Some GPs believe this leads to bias in deciding whether potential shared care patients go back to their GP or to the midwife clinic for delivery. There is also a midwife clinic at the hospital which antenatal patients can elect to attend after their initial hospital visit when they see a midwife. The midwife-led outreach clinics in community health centres, although advantageous to many patients, do not offer the type of 'whole patient care' that is encompassed by general practice.

Communication between midwives and GPs is aided by the existence of the antenatal shared care project and recently by the appointment of a midwife in the liaison role of 'shared maternity care coordinator'.

## Conclusion

The shared care project has been operating since 1994. Regular meetings of midwives, obstetricians and division personnel are held to 'iron out' any difficulties and to make appropriate changes to protocols. The process has been subject to continual evolution in response to new challenges, advances in obstetric care and the needs of patients and medical personnel. Both GPs and patients have enhanced the project and general acceptance and participation is good.

Conflict of interest: none declared.

### References

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