Family Physicians as Prenatalists: How a shared care model can improve prenatal access in rural South Carolina

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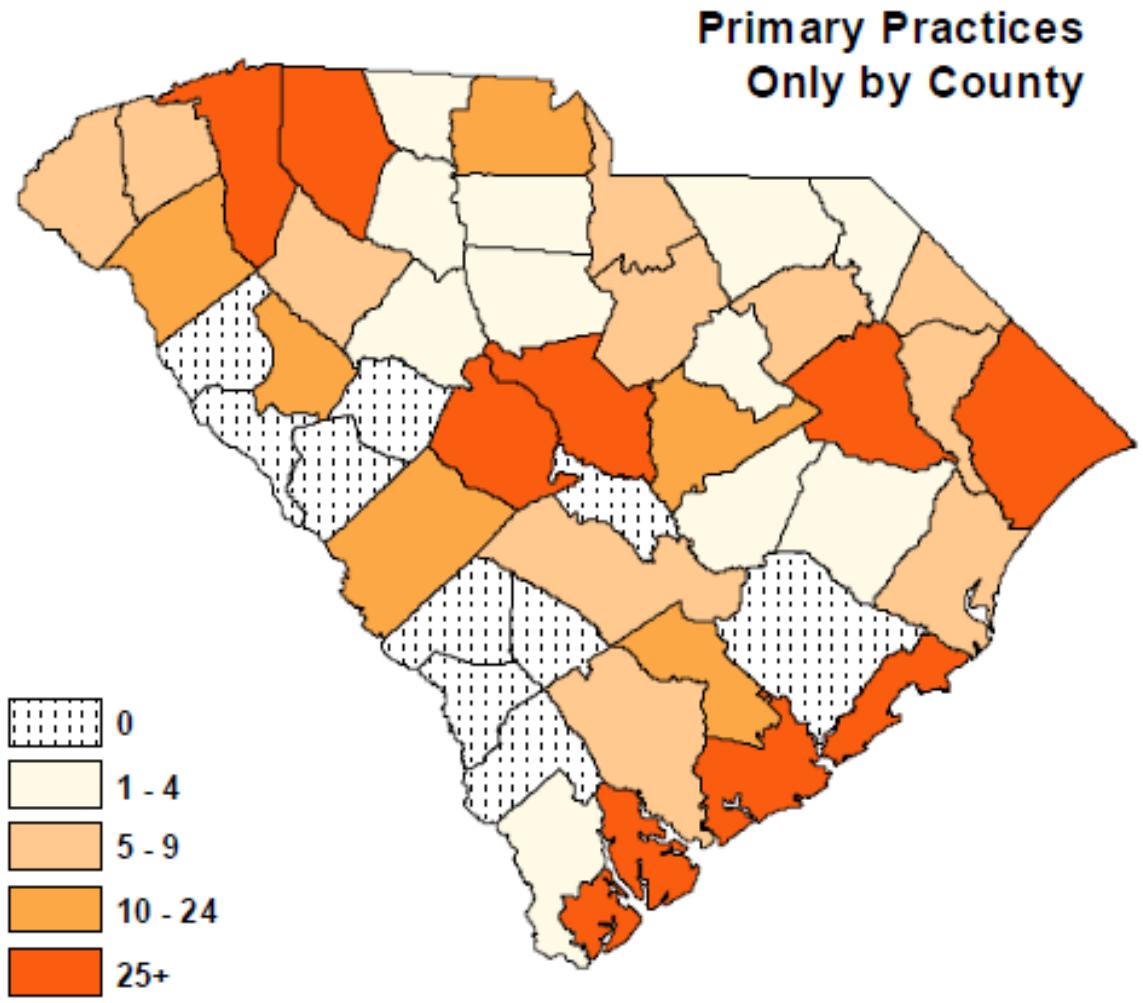
Shared Care:
Rationale and Overview

- Access to Maternity Care is highly variable in SC
- Barriers to providing Maternity Care in rural areas
- How Prenatalist family physicians may fill the gap
- Obstacles to Prenatalist care

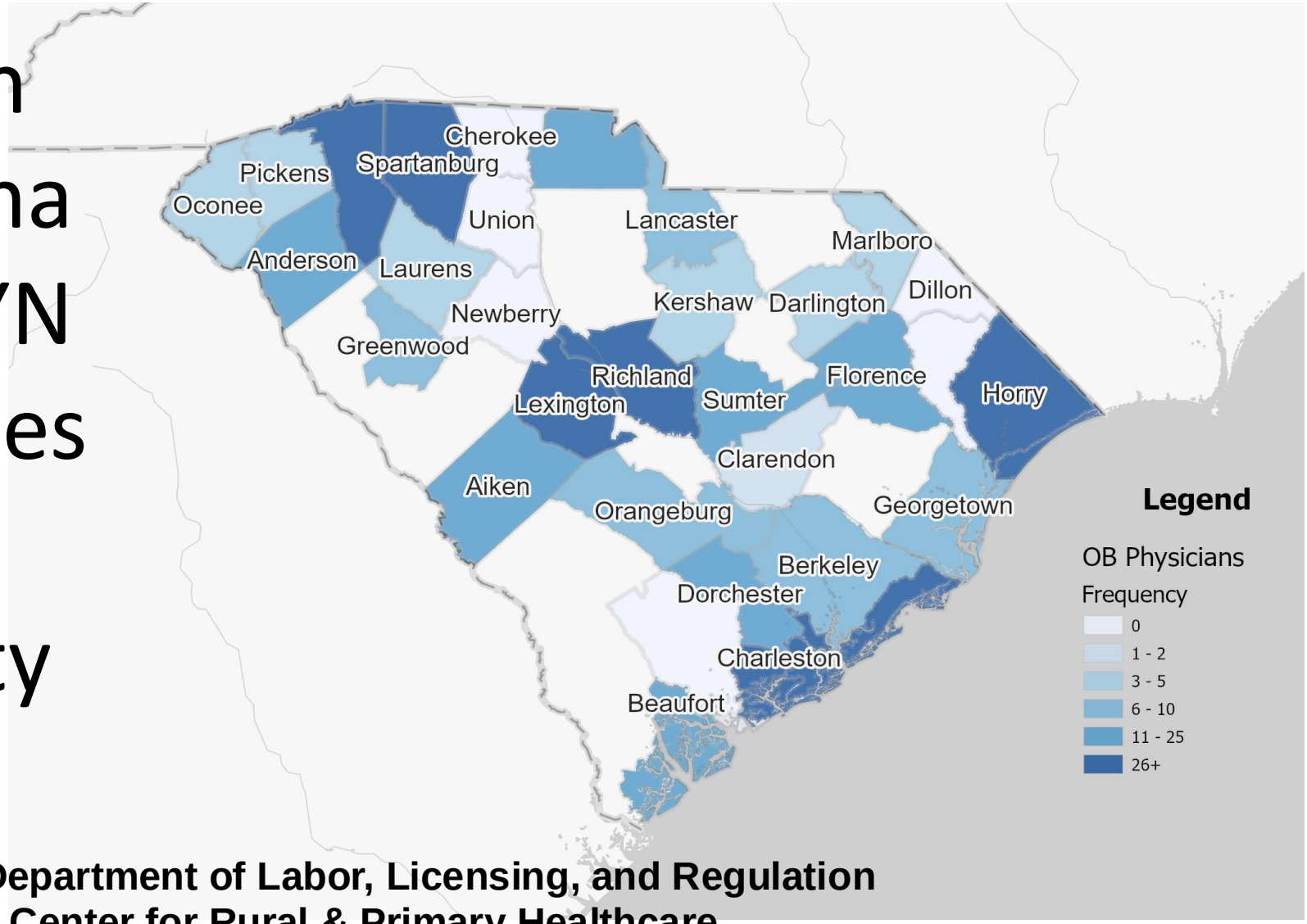
South Carolina OB/GYN Practices by County



PRMM
Division of Policy and Research on Medicaid and Medicare
Institute for Families in Society | University of South Carolina
Map created July 2013.

Sources: SC MMIS, December 2012; Maximus, March 2013

South Carolina OB/GYN Practices by County



Data from SC Department of Labor, Licensing, and Regulation
South Carolina Center for Rural & Primary Healthcare

D H E C PROMOTE PROTECT PROSPER	Live Births For South Carolina Residents			P H S I S PROMOTE PROTECT PROSPER
Multiple Counties				
Year				
	2010	2011	2012	2021
Region	Frequency	Frequency	Frequency	
Allendale	126	118	95	63
Bamberg	179	164	152	134
Barnwell	283	304	320	245
Hampton	263	212	230	193
Saluda	249	252	262	235
McCormick	75	53	55	63
Abbeville	251	278	253	222
Edgefield	166	157	205	176
Newberry	455	443	410	416
Richland	4871	4920	4779	4598
Lexington	3400	3255	3232	3389
Charleston	4845	4753	4685	5033
Spartanburg	3680	3541	3582	3875
Total	18843	18450	18260	

- http://scangis.dhec.sc.gov/scan/pregnancy/input.aspx Created 1 June 2014
- 2021 Data from SC Community Assessment Network (SCAN)
- South Carolina Center for Rural & Primary Healthcare

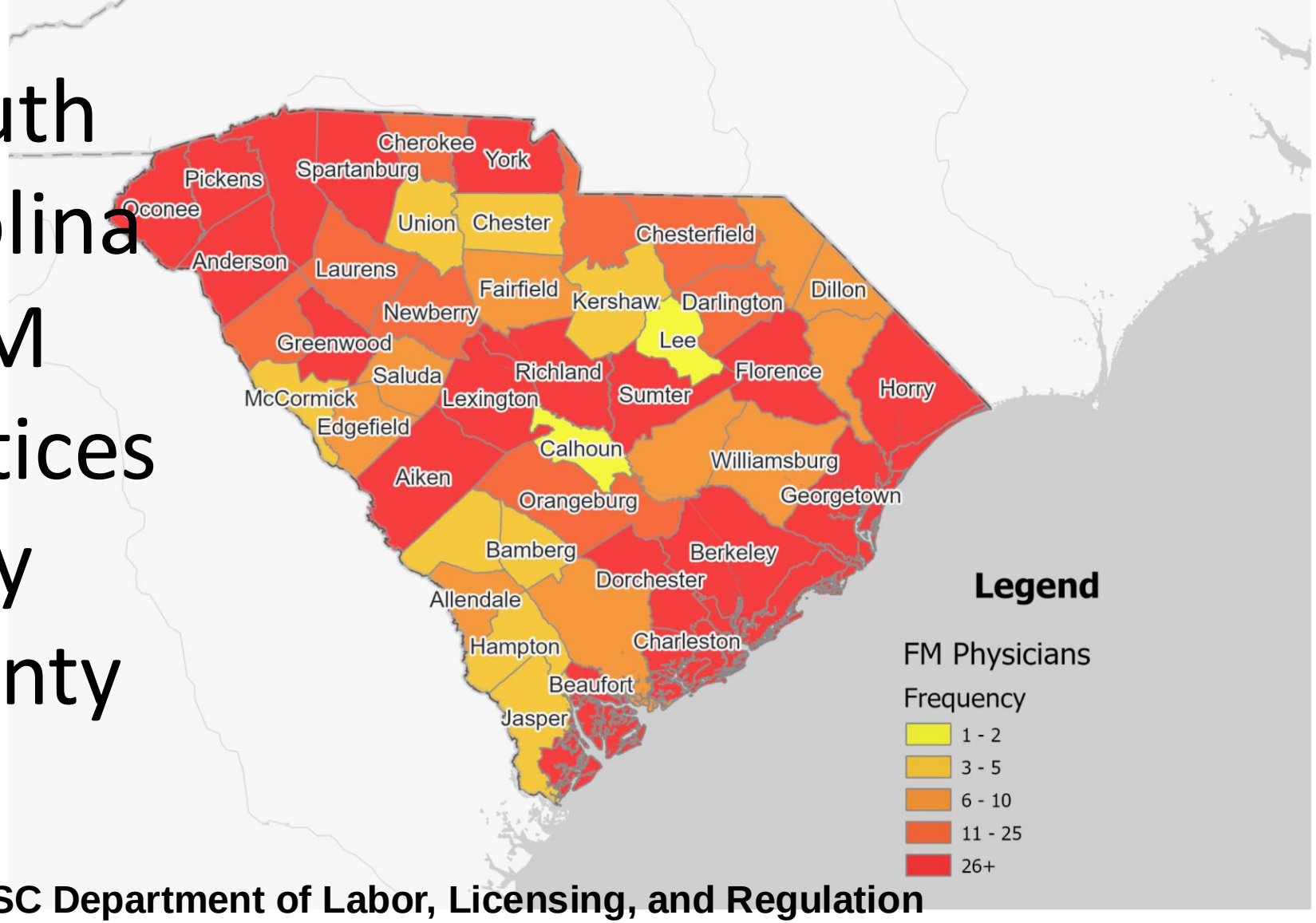
Barriers to Maternity Care in Rural Areas - who will do it?

- OB/GYNs?
  - Volume may not be adequate to sustain a practice.
    - Most doctors want 120-150 deliveries per year
    - Reaching that number in Rural counties can be hard
    - Lifestyle is difficult if you're the only doctor in the county.

Barriers to Maternity Care in Rural Areas

- OB/GYNs?
  - Need a place to deliver – with OR and Anesthesia
    - May not be a delivering hospital in the county
    - Hospital also needs a certain volume
- Midwives?
  - Have the same barriers to rural care as OB/GYN's
    - Need a place to deliver
    - Volume an issue to sustainable practice
    - Need a relationship with a delivering physician

South Carolina FM Practices by County



Data from SC Department of Labor, Licensing, and Regulation
South Carolina Center for Rural & Primary Healthcare

Barriers to Maternity Care in Rural Areas – who will do it?

- Family Medicine with Obstetrics?
  - Can handle a lower volume and remain viable
    - Twenty deliveries per doctor per year may work
  - Still requires a delivering hospital
  - Malpractice Insurance is a major barrier, especially at lower volumes
  - Are many residency graduates wanting to be a part of Labor care?

Can Prenatalists help fill the gap?

- "Prenatalist" – a physician who provides prenatal maternity care but does not provide intrapartum/labor care.

Prenatalist

- Prenatal care would be done in consultation with a physician or physician group that would plan to deliver the patient
  - Delivering physicians could have ***selected*** office or tele-visits with patients
    - End of first trimester? End of second trimester?
    - Weekly after 36 weeks? Trimesterly

Advantages of Prenatalist Care

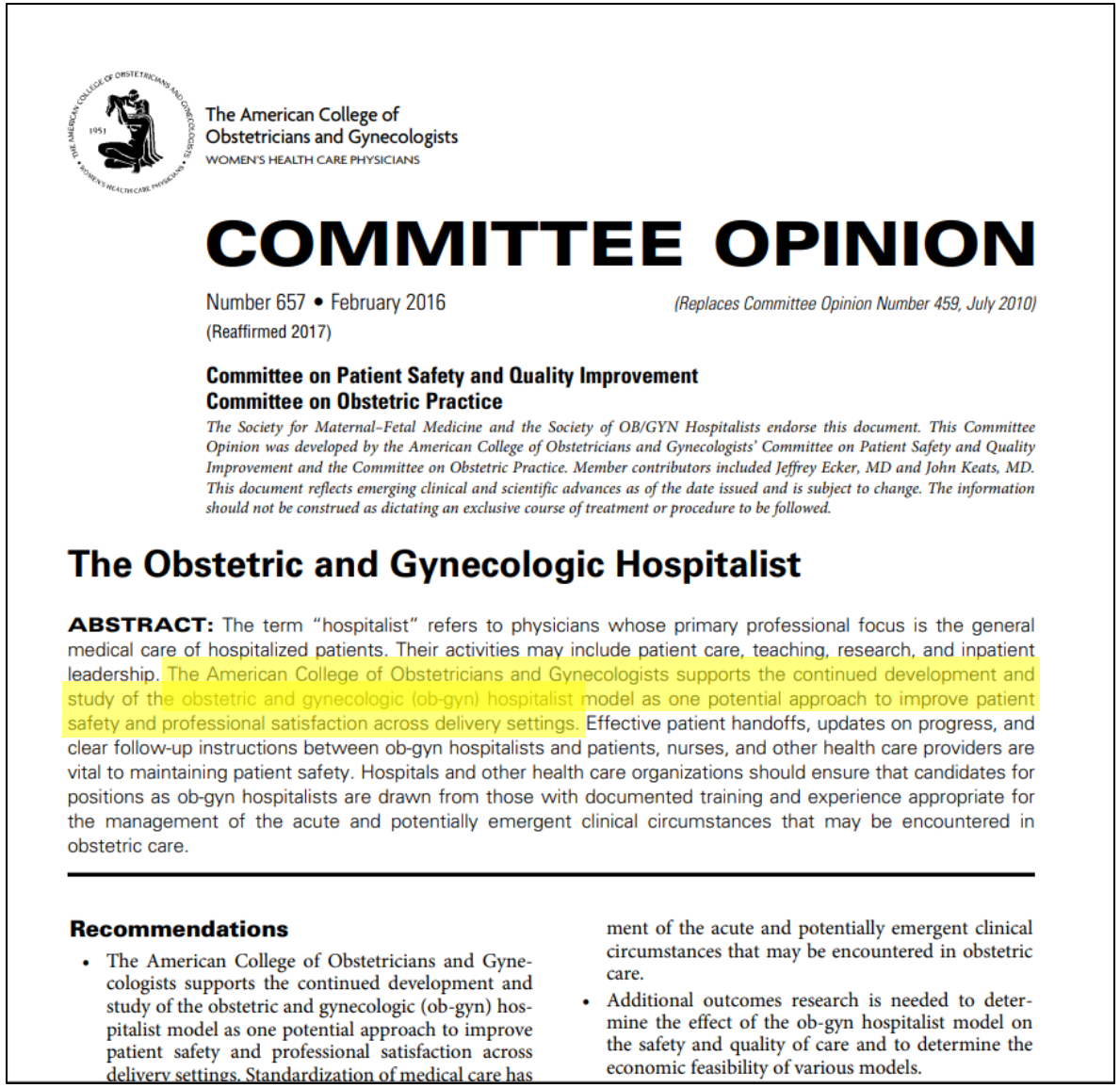
- To the Prenatalist physician
  - Maintaining continuity care with patients at a key point in their lives
  - Adding to the diversity of the practice
  - Revenue source for prenatal visits

Advantages of prenatalist care:

- To the delivering, or “Laborist” physician
  - Straightforward source of revenue
    - Deliveries
    - Ultrasounds
  - Strengthening other gynecologic referral patterns

Advantages of prenatalist care:

- To the patients:
  - FM physicians already established in the community and conveniently located
  - FM physicians likely already the patients' primary physician.
  - FM physicians will also take care of the child



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 657 • February 2016
(Reaffirmed 2017)

(Replaces Committee Opinion Number 459, July 2010)

Committee on Patient Safety and Quality Improvement
Committee on Obstetric Practice

The Society for Maternal–Fetal Medicine and the Society of OB/GYN Hospitalists endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Patient Safety and Quality Improvement and the Committee on Obstetric Practice. Member contributors included Jeffrey Ecker, MD and John Keats, MD. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

The Obstetric and Gynecologic Hospitalist

ABSTRACT: The term "hospitalist" refers to physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities may include patient care, teaching, research, and inpatient leadership. The American College of Obstetricians and Gynecologists supports the continued development and study of the obstetric and gynecologic (ob-gyn) hospitalist model as one potential approach to improve patient safety and professional satisfaction across delivery settings. Effective patient handoffs, updates on progress, and clear follow-up instructions between ob-gyn hospitalists and patients, nurses, and other health care providers are vital to maintaining patient safety. Hospitals and other health care organizations should ensure that candidates for positions as ob-gyn hospitalists are drawn from those with documented training and experience appropriate for the management of the acute and potentially emergent clinical circumstances that may be encountered in obstetric care.

Recommendations

- The American College of Obstetricians and Gynecologists supports the continued development and study of the obstetric and gynecologic (ob-gyn) hospitalist model as one potential approach to improve patient safety and professional satisfaction across delivery settings. Standardization of medical care has
ment of the acute and potentially emergent clinical circumstances that may be encountered in obstetric care.
- Additional outcomes research is needed to determine the effect of the ob-gyn hospitalist model on the safety and quality of care and to determine the economic feasibility of various models.

"The American College of Obstetricians and Gynecologists supports the continued development and study of the obstetric-gynecologic hospitalist model . . ."

Reaffirmed 2022

Barriers to Prenatalist care

- Philosophical
  - Increased fragmentation of care
    - Maybe not increased compared with current reality
- Practical
  - Splitting revenue between two groups
  - Malpractice coverage for prenatal care
  - Building confident relationships between prenatalists and delivering physicians

Practical Barriers: Dividing revenue

- Splitting Revenue for prenatal care is easy for Medicaid
  - Standard E+M codes for prenatal visits:
    - 99204 for Initial OB visit
    - 99212- 99215 for subsequent visits depending on complexity
  - Delivering doctor submits delivery code
- Splitting Revenue for Global payers is harder

Practical Barriers: Malpractice

- Federal Programs – not a problem
  - Military, Federally Qualified Health Centers, Veterans Affairs, Indian Health service
- JUA – implemented real Malpractice reform in 2014 for 4 pilot counties
  - Prenatal care will included in core Family Medicine scope of practice without an increase in premium
- Self-insured organizations may have more leeway

Practical Barriers: Building Confident Relationships between physicians

- Examples from residency and FQHCs
- Some of these relationships exist in current referral patterns
  - Specifics of shared care can be arranged between Laborist and prenatalist
    - Delivering physician could visit with patient:
      - After 36 weeks, or perhaps 36 weeks only?
    - Or perhaps a trimesterly chart review

Practical Barriers: building confident relationships between physicians

- Assistance (or interference) through telemedicine?
- Telemedicine/Virtual visits between offices
  - May be an avenue for some collaborative visits.
  - Probably not practical for all visits.

Practical Barriers: Telemedicine is secondary, not primary method

- Tele-visits between offices
  - Off-site consulting physician (MFM vs OB in the city) bills E+M code.
    - Medicaid payments: $41.20 / $69.40 / $102.6
  - On-site referring physician (rural physician) bills:
    - HCPS code Q3014: Facility charge ($14.96)
  - Not enough to cover making appointment/ rooming/ vitals/ Fundal measurement /FHT/ Urine/ Use of a room/ handling all the technical issues and patient phone calls

Additional Considerations

- Family Physicians even in rural areas are often employed within larger systems, and would need system approval to move forward.
  - May not be a barrier if “system continuity” is preserved.
  - Self-insured malpractice may be easier to manage

Prenatalist care -Summary

- Not new option
- Has some potential advantages for rural patient access
- Practical barriers are not insurmountable:
  - Malpractice coverage must cover prenatal care for Family Physicians
  - Medicaid in SC is well-suited for financial arrangement
  - Patterns of shared care and clinical confidence would need to develop.
- Telemedicine/virtual visits can facilitate communications between FM, MFM and community OB physicians – but should not be the primary visit strategy

Potential Barriers

- Little information so far as to how large-scale health care companies would react.
- Would need good strategy for monitoring outcomes