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# Midwifery Group Practice (MGP) a caseload model of care

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**"Midwife means with woman"**

*Photo courtesy of Deb Phillips, Midwife, NLR, AR*

# Midwifery Group Practice

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A review of Maternity Services in Queensland by Cherrell Hirst (2005) examined existing and future models of care in midwifery and recommended strategies to enhance experiences for women

Following extensive consultation with a wide range of care providers, a caseload model of care was implemented in October 2006

The model encompasses the recommendations of the Maternity Services review and facilitates continuity of care / carer which has been demonstrated to enhance positive health and satisfaction outcomes for both mothers and babies.





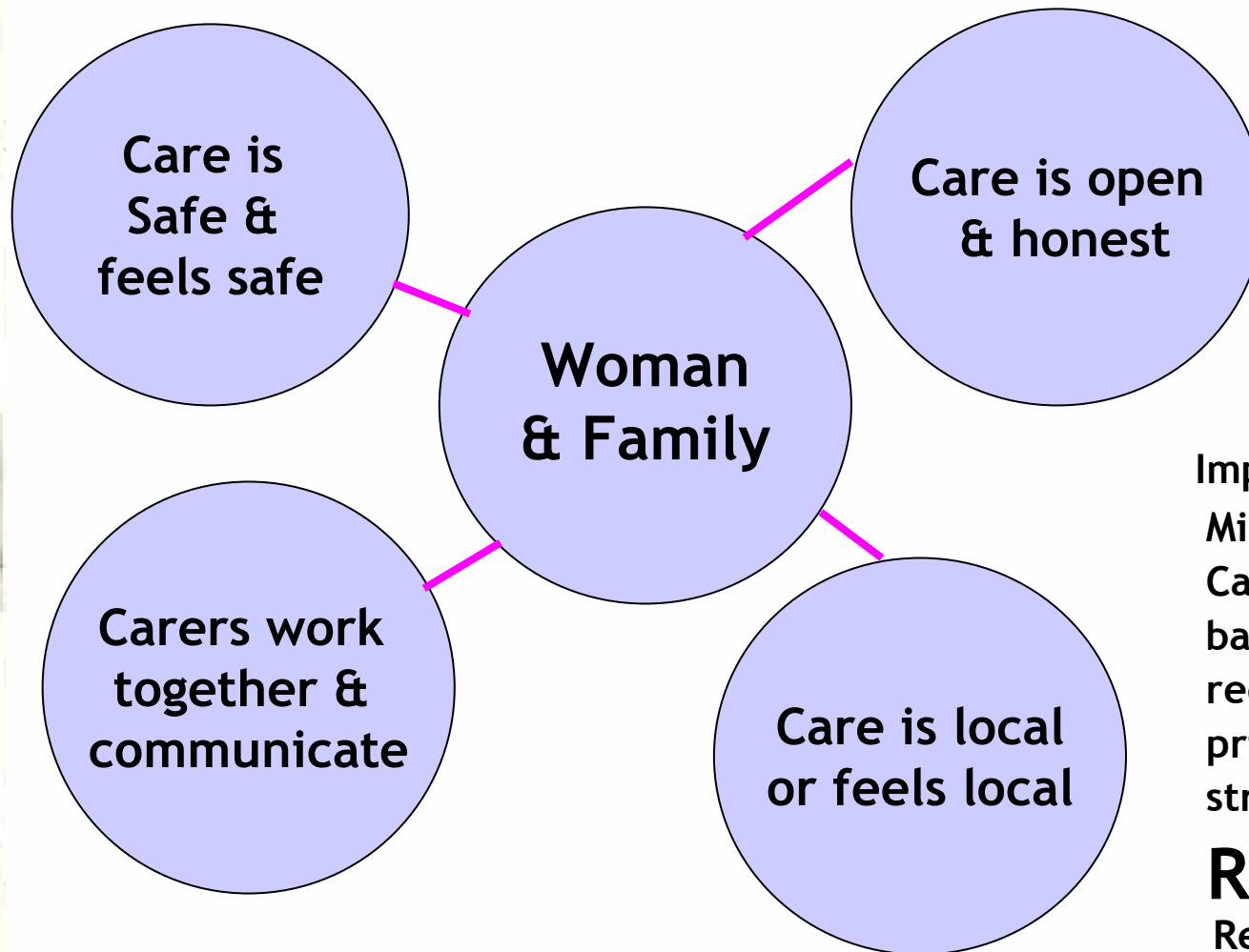
# Midwifery Group Practice Philosophy

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The philosophy of the Midwifery Group Practice (MGP) is to provide women centred care and continuity of carer during pregnancy, labour and the postnatal period in local communities, hospital and at home

The MGP works on a philosophy that pregnancy and childbirth is a normal physiological event and support women to birth with minimal interventions.

# Re-Birthing: Report of Maternity Services in Queensland ( Hirst, C. March 2005)



Implementation of Midwifery Models of Care need to be based on the recommendations, principles & strategies of the

**R**e-Birthing Report



## A Group Practice model of midwifery care

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MGP midwives manage own caseload: including supporting sick leave and annual leave taken within MGP

The midwives have the flexibility to organise their own working life, meeting the needs of women, colleagues and self.

Weekly meetings for case discussion, review and reflection (Stevens, & Mc Court, 2001; 2002)

Recognising that some women may develop complications in pregnancy, midwives work within the framework of their scope of practice as set down by the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for Midwives

To increase communication and teamwork; a nominated obstetrician provides obstetric support when required to the group practice enhancing continuity of Obstetric care







# MGP outcomes

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# The Women (326)

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Predominantly Caucasian (80%), with a small mix of Asian, Maori and African women

Mixed socio economic group with a large representation of low and middle income earners

Age range 19 to 43. Most women between 26 & 35

Each midwife aim's to care for a mix of multigravid and primigravid women to balance the workload

A small number of women (additional to the cohort) either chose alternative care, moved out of area or were deemed too complex to be suitable for this model of care



# Obstetric outcomes overall

<b>Onset of labour</b>	Spontaneous 77% / <b>84%</b>	Induced 15% / <b>13%</b>	ELCS 8% / <b>3%</b> Failed ECV for breech, placenta praevia
<b>Mode of birth</b>	SVD 73% / <b>77%</b>	Assisted vag 10% / <b>10%</b>	EMCS 9% / <b>10%</b>
<b>Analgesia in labour</b>	Nil / N2O 36% / 47% <b>Similar</b>	Opiates 16% / <b>18%</b>	Epidural 25% / <b>18%</b>



# Neonatal outcomes

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Of this cohort:

7 babies were born prematurely. 4 of these babies spent a short time in the SCN prior to their discharge home

1 baby was extremely premature (23 weeks) and died within a few minutes.

Only 1 term baby required significant resuscitation and was admitted to ICN (EMCS for APH)

9 term babies were admitted to SCN for a short period.  
Indications were: Respiratory distress (1 with thick mec),  
Suspected infection and hypothermia (BBA in ambulance)

3 term babies with Apgar scores of  $<7$  at 5 mins

All of these babies were discharged home well



# Breast Feeding Outcomes

	Breast	AF	Mixed
Birth	93% / 96%	3.5% / 2%	3.5% / 2%
D/C from MGP at 6 weeks	91% / 91%	3.5% / 2%	5.5% / 7%



# Cost Benefit Analysis 1

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Costing of this type of service is problematic due to the number of variables. However, the MGP financial review of the period October 2006 to March 2007 showed that this change in model of care saved approximately \$6,000 over the first 6 months

For this report assistance was been sought from the case mix department at Mater Health Services

It was possible to cost each woman's inpatient episode of care through the coded Diagnostic Related Group (DRG) which dictates how much money is received from Queensland Health

A comparison for costing was made with women on the MGP wait list who had already given birth in order to demonstrate the cost savings of the MGP model.

The women on the wait list were those who, had a position been available for them would otherwise have accessed MGP care and the associated benefits.



## Cost Benefit Analysis 2

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4 DRGs were identified to cost the outcomes of women in both the MGP and on the waiting list;

- Vaginal birth without severe complications
- Vaginal birth with severe complications
- Uncomplicated vaginal birth without another condition
- Caesarean section without severe complications

The cost of care for each individual identified woman in each category was measured and an average figure calculated

Based on this information it was demonstrated that MGP care could potentially save up to \$64,673 per 112 women who meet the inclusion criteria = \$577 / woman



# Summary

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The Mater Midwives' Partnership Program supports the provision of evidence based maternity care within a hospital and community setting as a safe and cost effective alternative to tertiary hospital based obstetric care

The safety and smooth running of the service supports the appropriateness of the MMH Guidelines for Consultation and referral

Evidence supports the fact that having a known midwife for pregnancy, birth and post partum:

- Enhances the experience of birth for the women involved
- Lowers the need for obstetric intervention and pharmacological pain relief in the birth process
- Empowers women

It also improves the work experience of the midwives involved



# Any questions

