GP Alignment Bridging Program

Dr Wendy Burton (MBBS)
Chair Alignment Committee / Clinical Lead GMSBML
Tionie Newth (BN & MMid)
GP Liaison Midwife
Goal

The aim of the MMH-GP Alignment program is to educate, equip and empower GPs to provide best-practice antenatal care to low-risk women. The MMH recognises the existing skill base of General Practitioners and is committed to working with GPs to identify and close gaps in current practice and in communication between MMH and providers of care.

Clinically competent GPs providing timely evidenced-based care to women in their local community is a model of care endorsed by the MMH. By working together, using resources appropriately and communicating effectively and efficiently, we aim to reduce the risks and improve the safety and outcomes for both mother and child.
Learning objectives

This bridging program is designed for GPs who have recently completed clinical updates elsewhere or who are updating their Alignment and who would benefit from information about the specifics of shared maternity care with the Mater, such as the

– referral process
– models of care available to women
– allied health clinics and
– lines of communication into the Mater Mothers Hospital.

You should also be aware of resources such as

• The current MMH MSC Guideline
• The materonline.org.au websites and a range of Qhealth resources
This 36 page Maternity Shared Care Guideline summarises the care of women and the roles and responsibilities of GPs and hospital staff.
This is a 306 page comprehensive, evidence based document focusing primarily on first trimester care. The 8 page summary is particularly helpful and there are specific chapters on care for ATSI and rural and remote women.
This QHealth site has a number of useful guidelines and educational resources, including ones relevant for GPs providing shared antenatal care.
The catchment area

- Mater Mothers’ Hospital is a private hospital contracted by Queensland Health to conduct an agreed number of public births per year. **Due to high demand it is not currently possible to accept routine low risk referrals from outside the catchment area.**
- Special consideration is made for Indigenous women.
- Women requiring tertiary care should be referred to their local maternity hospital and the obstetricians will liaise with MMH specialists.
- Women requiring a specialist drug and alcohol service may be considered on a case by case basis.
- The inclusion of information regarding medical and social risk factors will assist with the triaging of your referral. If further information is required please contact Mater Mothers' Hospital GP Liaison Midwife on telephone 07 3163 1861 (you can leave a message) email GLM@mater.org.au or mobile 0466 205 710.
Please note: this is a visual approximation of the catchment area. Women living within the catchment area will be accepted, however proof of address is required.
This postcode list gives more accurate detail on the catchment area.

<table>
<thead>
<tr>
<th>Antenatal Clinic Catchment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
</tr>
<tr>
<td>Acacia Ridge</td>
</tr>
<tr>
<td>Alcheringa</td>
</tr>
<tr>
<td>Algeste</td>
</tr>
<tr>
<td>Altandi</td>
</tr>
<tr>
<td>Annerley</td>
</tr>
<tr>
<td>Archerfield</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>Balmoral</td>
</tr>
<tr>
<td>Balmoral Heights</td>
</tr>
<tr>
<td>Rannoch</td>
</tr>
</tbody>
</table>
### Obstetric
- Obstetrician
- Obstetric registrar
- Midwife
- Location:
  - MMH Tuesday to Friday
  - Inala Wednesday

### Obstetric Medical
- Obstetrician
- Obstetric registrar
- Obstetric physician
- Location: MMH Tuesday to Friday

### GP Share Care
- Midwife history
- Obstetrician/Obstetric registrar at booking appointment
- GP routine visits
- MMH at K36 midwife/obstetrician

### Midwives Clinic
- MMH daily
- Inala Tuesday to Friday
- West End <21yrs Friday
- QEII Friday afternoon/evening
- High psychosocial risk MMH Tuesday

### Refugee Clinic
- MMH
  - Monday: Midwife/Social worker
  - Thursday: Midwife/Obstetrician/Obstetric physician/Social Worker

### Indigenous Clinic
- MMH Thursday
- Obstetrician
- Obstetric Registrar
- Obstetric physician
- Midwife

### Diabetic Clinic
- MMH Tuesday
- Obstetrician
- Endocrinologist
- Diabetic Nurse Educator
- Midwife
- Dietician

### Pregnancy After Loss Clinic
- MMH early review if last pregnancy IUFD, stillbirth or neonatal death
- **CHAMP**
  - Recent or current drug and alcohol use.
  - MMH Wednesday

### Midwifery Group Practice
- Coorparoo
- Corinda
- Inala
- Westend <21y
- ATSI Birthing in Our Community
- Obstetrician/Obstetric registrar at booking

---

*Exceptional People. Exceptional Care.*
Mater Models of Care

• MMH has a number of specialised models of care. Identification of indigenous status, refugee background, social risk, drug and alcohol use or previous pregnancy loss will assist with triage to the appropriate clinic.

• Women may choose to have GP share care but their booking appointments and assessment will occur in the specialist clinic.
The Midwifery Group Practice (MGP) provides woman centred care and continuity of carer during pregnancy, labour and the postnatal period in local communities, the 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.
- The MGP provides an community based ‘group’ approach to antenatal care and education. It assists women to develop social networks and support within their own community.
- Clinics are held at Coorparoo, Corinda, Inala, Woolloongabba (for Aboriginal and Torres Straight Islander women) and West End (for women < 21).
Midwifery Group Practice

- MGP is for Medicare eligible women who live in the Mater Mothers catchment
- It is not suitable for women who require an interpreter
- MGP is for women planning a vaginal birth
- MGP accept women with various levels of risk, including suitable women wanting vaginal birth after caesarean section
- Women have an allocated midwife they can contact by mobile
- The booking appointment is at the woman’s home
- Antenatal appointments and education are conducted in a group setting
- The allocated midwife or one of her colleagues will care for the woman during the birth and postnatally
- Women are usually discharged home on the day they give birth
Midwifery Group Practice

- Young Mothers Group Practice (YMGP) is for women <21 especially those with complex social needs
- Aboriginal and Torres Straight Islander Birthing in our Community group meets at the ATSICHS in Woolloongabba
- All women including MGP have an obstetric booking appointment
- MGP midwives work in consultation with an obstetrician

This is a high-demand model of care so get the referrals in EARLY!! (as soon as the due date is established)
Information is available online for women regarding their options for antenatal care.

Please inform women of their different options and indicate on the referral form which model of care they have chosen.
The template

- Antenatal clinic receives **200-400 referrals each week**. The information that GPs provide is critical to a safe, effective and efficient triage process.
- Identify medical and social risk factors and the indication for early appointment. Contact the GP Liaison Midwife if you need advice.
- The use of the MMH referral template is mandatory. If you send a referral in that is not on the MMH template, it will not be accepted.
- Please cc MMH ANC on all investigations
- Please use the most current template, as decision support is included and regularly updated e.g. OGTT testing, additional testing recommended for women with a BMI > 35 such as E/LFT, OGTT, urinary Protein/Cr ratio
Please tick a box...

A named referral is required by Mater Mother’s Hospital, so please tick a box.
Please nominate risk and reason for early assessment

- This patient requires early assessment: [ ] Yes, [ ] No
- Estimated Risk: [ ] Low, [ ] High
- Identified Risk Factors (obstetric, medical, psychosocial) and or reason for early assessment:
Please attach copy AND cc MMH ANC

- Having a copy of the results (if available) in the referral helps to triage a woman
- Having an electronic result sent to MMH makes it easier for clinicians to find
- Including a copy in the pregnancy health record improves communication with external providers of care
Who is responsible for abnormal results?

• The clinician who orders the test is responsible for the follow up
• Although a copy of the result is sent to MMH, it is entered into their system *without* being seen and is only reviewed when the woman comes for an appointment or contacts the hospital for advice
• There are guidelines for consultation and referral and managing abnormal results available in sections 6 and 12 of the MMH GP Maternity Shared Care Guideline [www.materonline.org.au/services/maternity/health-professional-information/guidelines-and-policies](http://www.materonline.org.au/services/maternity/health-professional-information/guidelines-and-policies)
Referral process

- Women with pre-existing medical conditions should be referred to a named obstetrician on the antenatal referral template. The obstetrician will consult and refer to the obstetric medicine specialist as appropriate.

- If an already booked woman develops a medical condition during her pregnancy, please fax a letter to ANC (not another antenatal referral form) including the relevant clinical details, so that the appropriate referrals can be organised.

- If you are uncertain about the best approach to take in caring for or referring a woman, or if the woman requires urgent review, phone the on call consultant (3163 6009), registrar (3163 6610) or the GP Liaison Midwife (3163 1861, leave a message prn or 0466 205 710)
Ultrasound scans/Maternal Fetal Medicine (MFM)

- MMH does not have the capacity to do routine scans for the 5000 + public women per year. Please direct your routine scan referrals to private providers.
- Notify antenatal clinic of high risk USS results by faxed letter and include the ultrasound report. An urgent obstetric appointment will be allocated for counselling and referral to MFM.
- If you send a named referral to MFM for a scan or procedure this does NOT replace the need to send a named referral to ANC.
- MMH does not perform terminations of pregnancy or provide contraceptive services.
Please encourage women to book and attend Antenatal classes
EPAU

• The Early Pregnancy Assessment Unit (EPAU) is a specialist area in the Mater Mothers’ Hospital that deals specifically with problems in early (< 20/52) pregnancy.
• The most common problems are vaginal bleeding or pain. They manage threatened and incomplete miscarriages and investigate causes of pain.
• Haemodynamically unstable women should be directed to A & E.
• They are open on weekdays from 8:30 am to 11:30, by appointment only.
EPAU

- In addition to surgical management of miscarriages and ectopic pregnancies, the EPAU is able to offer medical management to suitable women
- They do not look after women with hyperemesis
- Women from outside the catchment area are welcome to use this service, however it will not entitle them to antenatal care at MMH in a current or subsequent pregnancy
Incomplete miscarriage treatment options

**Expectant**
- follow up USS if still bleeding after 2 weeks OR if painful, heavy bleeding

**Medical management** (initiated by hospital)
- Misoprostol has proven effective in 80 – 85% of miscarriages < 13/52
- x 2 doses administered PV on consecutive days
- bleeding and pain occur ~ 2-4 hours after the first dose and lasts up to 24-72 hours before the miscarriage is completed
- period-like bleeding will then occur over the next week or so
- ~ 10% of women have excessive pain or bleeding—medical review and possibly D & C may be required
- hospitalisation for heavy bleeding or infection occurs in < 1% of women
- *not* TGA registered for use in pregnancy. Use supported by QHealth and RANZCOG

**Surgical management**
PAOU

• The Pregnancy Assessment and Observation Unit is for the review of urgent pregnancy related concerns
• PAOU is located adjacent to Birth Suites on level 5 of the MMH
• GP’s should contact the PAOU before sending a woman in for assessment. Team leader 3163 6577. Registrar 3163 6611
• Women can self refer by calling 3163 7000
• The PAOU is open to women booked at Mater Mothers Public and Private Hospitals
PAOU

• Common presentations would include:
• Preterm labour
• Uncertainty about or premature rupture of membranes
• Reduced fetal movements
• Review of hypertensive women referred by their GP, obstetrician or midwife
• Bleeding after 20 weeks
Physio services at MMH

• Obstetric Physiotherapists
  – Antenatal / Postnatal, inpatient, outpatient and exercise classes
  – Musculoskeletal dysfunction
  – Continence / urgency / prolapse

• Pelvic floor Physiotherapists
  – Incontinence and prolapse
  – Pelvic pain
  – Chronic constipation
Early referral needed:

- Anterior and bilateral SIJ pain
- History of significant Lumbar/pelvic pain, surgery or trauma
- Early onset of significant symptoms – particularly pubic symphysis pain and Carpal Tunnel Syndrome
Physio MMH contact details

• Public Outpatient service including classes
  – no referral required if booked in to Mater Mothers’ Hospital but is helpful for background information
  – Ph 07 3163 6000 OR fax to 3163 1671
  – Can arrange for urgent appt if required (best to call)

• Private Outpatients - Health & Wellness Clinic
  – Ph 07 3163 6000
  – patient can self refer or Doctor’s referral

• Websites: http://wellness.mater.org.au
  http://brochures.mater.org.au (MMH or MMPH, enter “physiotherapy” into the search tab for a range of brochures for women)
Physiotherapy referrals

• Women who are registered to have or who have had their baby at MMH are eligible for public physiotherapy services; refer women using a standard practice referral. The wait times for antenatal women are short.

• Most public patients will be eligible for services within the hospital at no charge; however there may be a fee associated with some products and services.

• Please speak with our staff for any further information regarding access to these services on Ph 3163 6000 and follow the prompts.
Testing for Diabetes in Pregnancy changes effective Sept 2011

• Early pregnancy testing – random venous plasma glucose (RVPG) for low risk women, proceed to OGTT if RVPG ≥ 8.0 mmol/L
• Early OGTT for high risk women
• **No** glucose challenge testing
• Routine OGTT (24 – 28 weeks) for all women not previously noted as abnormal
• OGTT criteria unchanged at present
Testing for Diabetes During Pregnancy - Algorithm

At diagnosis of pregnancy

Major clinical risk factors for overt diabetes/early GDM:
- Obesity (BMI > 30)
- Previous GDM
- Polycystic Ovarian syndrome
- Previous macrosomia
- High risk ethnic group

Offer 75 g GTT

Negative

Positive

Refer to:
- GDM education clinic
- Obstetrician who will refer to Physicians/Endocrinologist

Pregnancy care through type 1 and Type II schedule, antenatal clinic MHMH

At 26 to 28 weeks gestation

Negative

Positive

Refer to:
- GDM education clinic
- Obstetrician who will refer to Physicians/Endocrinologist

Pregnancy care through GDM schedule, antenatal clinic MHMH

Woman continues on chosen care paths
Gestational Diabetes Mellitus

- Notify ANC when the diagnosis is made via referral letter faxed to ANC or phone call plus referral
- Advise the woman she will be seen in the Thursday GDM clinic, where she will be reviewed by a diabetes educator and a dietitian week 1 and an endocrinologist week 4, earlier if BSL control is poor
- Her care will transfer back to MMH and she will have tertiary care in an obstetric clinic
- The main treatment is diet and BSL monitoring, however medications, including metformin or insulin, may be required
- A clinical trial commenced in Feb 2014 with suitable low risk women having midwifery or GP shared care receiving community care of their GDM at the UQ PACE clinic at Annerley. They will continue to have antenatal care with their midwife or GP, rather than receiving the above hospital based care
Gestational Diabetes Mellitus

Tight sugar control is recommended;
• fasting BSLs of < 5.0
• 1 hour post prandial of < 8.0
• 2 hour post prandial of < 7.0

The figures above may change soon as per ADIPS*

The figures vary, but women with GDM have ~ 50% risk of developing Type 2 DM in the next 10-20 years, hence the following recommendations

* [www.adips.org](http://www.adips.org)
Postnatal care of women with GDM

Recommendations:

• Oral glucose tolerance testing six–eight weeks postpartum to exclude diabetes (*cc MMH please*)
• Follow up oral glucose tolerance testing at least two yearly (possibly at time of the cervical screening)
• Repeat oral glucose tolerance test prior to or early in next pregnancy
• Follow up of impaired fasting glucose by twice yearly checks for frank diabetes in addition to assessment of other risk factors of macrovascular disease
Obesity in pregnancy

For women with a BMI > 35 kg/m²

- Routine scheduled bloods are recommended plus E/LFT, OGTT, and urine protein/creatinine ratio
- Advise women to take 5 mg of Folate daily preconception and in the first trimester as they have a higher risk of impaired glucose tolerance
- Advise the hospital of the woman’s BMI so they can organise appropriate internal referrals, such as referral to an anaesthetist; consider her suitability for a modified model of care
- If the first trimester OGTT is negative, an OGTT is to be performed at 26-28 weeks
Obesity in pregnancy

- It is recommended that women with a BMI > 30 are **weighed** at each visit **AND** that they have a regular urinalysis
- Advise women of their target weight gain (see table in PHR)

### Target weight gains

<table>
<thead>
<tr>
<th>Pre-pregnancy BMI (kg/m²)</th>
<th>Rate of gain 2nd and 3rd trimester (kg/week)*</th>
<th>Recommended total gain range (kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 18.5</td>
<td>0.45</td>
<td>12.5 to 18</td>
</tr>
<tr>
<td>18.5 to 24.9</td>
<td>0.45</td>
<td>11.5 to 16</td>
</tr>
<tr>
<td>25.0 to 29.9</td>
<td>0.28</td>
<td>7 to 11.5</td>
</tr>
<tr>
<td>Greater than or equal to 30.0</td>
<td>0.22</td>
<td>5 to 9</td>
</tr>
</tbody>
</table>

*Calculations assume a 0.5–2 kg weight gain in the first trimester for single babies. Refer to dietitian if multiple pregnancies, as different goals required.
The weight tracker

This evidence-based tool, developed by MMH dietitians, helps start the conversation about healthy weight gain. It allows you to:

1. Discuss goal weights, depending on pre-pregnancy BMI
2. Indicate recommended weight gain trajectories
3. Support women know when greater support is required around healthy eating and exercise (when tracking occurs outside the shading for >2 weeks)
Obesity guidelines

health • care • people

MATERNITY & NEONATAL

Queensland Maternity and Neonatal Clinical Guideline

Obesity
Dietitian referrals

All MMH women can be referred to the MMH Dietitian

• Referrals accepted any time, but <20 weeks preferred (can be sent with initial referral)
• Most women will be booked into the daily ‘Healthy Start to Pregnancy’ group (please advise them of this). They will then be offered 1:1 appointments for ongoing support
• Early referral provides the ability for advice, intervention and support around adequate and appropriate nutrition, including supplements, optimising gestational weight gain

Referral is specifically encouraged for:

• Women with poorly controlled T1DM/T2DM, Young women (<20yrs), Multiple allergies, Multiple pregnancy, gastric band, Weight gain outside the tracker > 2 time points, Hyperemesis Gravidarum, ‘Active’ eating disorder, Nutrition related co-morbidity e.g. coeliac disease, iron deficiency, Crohn’s disease/ulcerative colitis
How to broach recommended weight gain with patients

• Discuss:
  – Pre-pregnancy BMI
  – Recommended range
  – Risks of too little and too much weight gained
  – Resources/services available to support this @ MMH

“Based on your weight at the beginning of pregnancy, this weight gain is recommended for the healthiest pregnancy possible”

<table>
<thead>
<tr>
<th>If pre-pregnancy BMI was ...</th>
<th>You should gain ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 18.5 kg/m²</td>
<td>12.5-18kg</td>
</tr>
<tr>
<td>Between 18.5-25 kg/m²</td>
<td>11.5-16kg</td>
</tr>
<tr>
<td>Between 25-29.9 kg/m²</td>
<td>7-11½ kg</td>
</tr>
<tr>
<td>Above 30 kg/m²</td>
<td>5-9kg</td>
</tr>
</tbody>
</table>
Referral process

Women can self refer, or you can use the referral template available at materonline.org.au
→ Quick Referrals
→ Allied Health

Or your standard practice referral
Antenatal thyroxine management

• In women with hypothyroidism, their TSH should be less than 2.5 before and during pregnancy.

• Thyroxine dose requirements increase in pregnancy – it is recommended that well controlled women increase their dose of thyroxine by 30% at the time pregnancy is confirmed, which practically translates into taking an extra dose twice a week e.g. Mon, Thurs.

• In women with known hypo or hyper thyroidism, TFT should be checked regularly (around every 6 - 8 weeks) throughout pregnancy.

• Thyroxine dose can generally be decreased again once the pregnancy concludes.
Thyroid tips

• Routine testing of TFT in pregnancy in low risk women is not recommended
• TSH generally drops in the first trimester with the rise in HCG
• For a suppressed TSH lower than the lower limit of the lab reference range, check the Free T4. Women with a suppressed TSH and normal range Free T4 are normal and do not need referral
• Those with suppressed TSH and elevated Free T4 need clinical review and possibly referral
Summary of routine bloods

- Routine first trimester ANS = FBC, Blood group and antibodies, Rubella, Hep B, Hep C, HIV, Syphilis, RVPG and MSU m/c/s. (Pap if due)
- Women with BMI > 35 to have OGTT, E/LFTs, urinary protein/creatinine ratio as well as the above
- 26-28 week bloods = FBC, OGTT and Blood group antibodies
- 36 week bloods = Hb
Summary of ultrasound scan recommendations

• Women who have uncertain dates should be offered a dating scan
• Women with bleeding should be offered a viability scan
• All women should be offered the following scans in pregnancy:
  – A Nuchal Translucency Scan (between 11 and 13 +6 weeks gestation) in combination with B HCG and PAPP-A
  – A Morphology Scan (between 18-20 weeks)

Women may, of course, decline to have any or all of these scans
Preconception Clinic

- MHS offers a preconception clinic which is open to referrals of any women who are interested in preconception care. This is for low as well as for high risk women and is not limited to women from within the MMH catchment area. Please forward a named referral to the Mater Adults Hospital Gynaecology Clinic, identifying the reason for the referral and including copies of any relevant results.

- Women are seen by a midwife who works through a structured questionnaire and the woman then consults a gynaecologist. Appropriate further investigations are organised where indicated and further advice is given.
Fertility Clinic

• The MHS offers couples who are experiencing difficulties conceiving the options of work up and review within their fertility clinic. All couples will have a preconception appointment and GPs are requested to send a named referral to the Gynaecology Clinic and to include results of the initial work up, specifically sperm count, blood work to confirm ovulation and imaging of the pelvis, including Day 5-10 salpingohysterogram or sonohysterogram.

• Couples have a structured work up, are invited to participate in research and are offered Clomiphene for women with anovulation however Mater, along with other QHealth funded services, does NOT offer assisted reproductive technologies.
Preconception and fertility clinics

Women do not need to live within the MMH catchment area to be referred to these clinics, however having been seen at these clinics does not entitle them to obstetric care at MMH.
Lactation Services

• The Mater Mothers’ Hospital runs a Breastfeeding Support Centre to assist both in-patient and outpatient women and babies successfully breastfeed

• Inpatient service: by referral from the Medical Practitioner or a midwife

• Outpatient service: self referral, GP or Obstetrician referral, Child Health etc

• Women do not have to have birthed at the Mater to see a lactation consultant
Breastfeeding Support Centre

- There is an $100* fee for an initial postnatal lactation consultation which may be redeemable through certain health funds (women should check).
- Consultations are typically 1-1 1/2 hours (possibly longer according to individual need) and there are 4-5 consultations available each day Mon-Fri
- An antenatal service is also provided at a $50* fee (1/2-1 hour)
- Family members are welcome to attend
- Supporting literature and a written feed plan is provided upon completion of the consult.
- Phone consultations are available Ph 3163 8200

* Correct as of March 2014
www.materonline.org.au/services/maternity/health-professional-information/guidelines-and-policies
www.materonline.org.au

- Has a range of resources including a significant body of information about the Alignment program and shared antenatal care
- GPs can sign up to receive an electronic, self-populating referral templates for MMH, Mater Adults and Mater Children’s Hospitals
- Hyperlinks to the Greater Metro South Brisbane Medicare Local, which hyperlinks to resources for clinicians and for women
- Can be used to research specialists and pre-referral guidelines
- Mater Adults Hospital referral guidelines include information about expected waiting times for patients
Please consider signing up

- Mater Health Services have created a web site for where, among other things, women can look at the models of care available at MMH. Women who do not have a GP can use this tool to locate an aligned GP. If you consent being on this list, a woman could search for and find you on the mater.org.au site.
Online education resources

QHealth has a range of power points, video conferences, knowledge assessments and flowcharts available online which flow from their Maternity and Neonatal Guideline work. GP relevant topics include Obesity, Early Pregnancy Loss, Vaginal Birth after caesarean section (VBAC), Breastfeeding initiation, Examination of the Newborn and Neonatal Jaundice

Contact details

Maternity Share Care issues?
   GP Liaison Midwife Phone:  3163 1861
   E-mail: GPL@mater.org.au
   Mobile: 0466 205 710

If you are uncertain about the best approach to take in caring for or referring a woman, or if she requires urgent review, phone the on call consultant (3163 6009), registrar (3163 6610) or the GPLM (Mon-Fri)
Contact details

Alignment status, contact details & evaluation enquiries?
Sarah Renals
Phone 3163 1967
Email MSCAlignmentAdmin@mater.org.au.

Training & RACGP enquiries?
Mater Marketing
Phone: 07 3163 1524
Email: marketing@mater.org.au
Item numbers for MSC

16500 Rebate $40.10 ($47.15) Antenatal Attendance

16591 Rebate $121.30 ($142.65) “Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery if the care of the patient will be transferred to another medical practitioner, payable once only for any pregnancy that has progressed beyond 20 weeks, not being a service to which item 16590 applies” (16590 = planning to undertake the delivery for a privately admitted patient)
Please watch out for Ahead of the Curve (AOTC) our newsletter

We will keep you updated e.g. about changes to the GDM criteria, guideline alterations, education events
What should you expect from MMH?

- Communication e.g. antenatal summary, discharge summary, EPAU correspondence, AOTC
- cc results from MMH
- Telephone or email support for GPs
- Opportunity for face to face updates through the Alignment program or through Mater Health Services education events