The Value of Implementing Multidisciplinary Perinatal Care Conference in the Private Practice Setting

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Am J Perinatol Rep 2017;7:e201–e204.

Abstract

Objective The objective of this study was to estimate the impact of multidisciplinary (Multi-D) perinatal care conference (PCC) implementation in the private practice setting.

Methods After the initial 12-month period following implementation of the monthly PCC by private maternal–fetal medicine and neonatology practitioners, conference attendees were asked to completed a modified version of the Attitudes Toward Health Care Teams Scale, involving 19 questions assessing their attitudes and opinions toward Multi-D team care on a five-point Likert’s scale.

Results Of the 51 average attendees to the PCC, 82.3% completed the survey. A majority of respondents agreed that Multi-D team care resulted in improved care for patients and family, was not overly complex to coordinate, and resulted in significant job satisfaction and improved medical knowledge.

Conclusion Multi-D care is an effective approach to the complicated needs of maternal–fetal medicine patients which may lead to improved patient and family outcomes, high provider satisfaction, and can easily be implemented and utilized within a private practice or community hospital setting.

Keywords
► multidisciplinary
► perinatal
► care conference
► high risk
► fetal

A significant number of pregnancies every year are considered high risk. These include, but are not limited to complications such as hypertension, diabetes, multifetal gestation, advanced maternal age and congenital fetal anomalies.1,2 For instance, 6 to 8% of pregnant women in the United States have high blood pressure, and between 2 and 10% suffer from gestational diabetes. Approximately 1 in every 880 U.S. births in 2014 was a triplet or higher order gestation.3 As more couples choose to delay childbearing, the number of women aged 35 to 39 and 40 to 44 years has steadily increased across the United States since 1980, and now account for 11.0 and 2.3 per 1,000 births, respectively.4 Finally, approximately 1 in every 33 infants in the United States is born with a birth defect, and account for 20% of all infant deaths.5

Maternal–fetal medicine (MFM) specialists often encounter these complex patients and are tasked with coordinating their multidisciplinary (Multi-D) prenatal, intrapartum, and neonatal care. This includes preconception care for women with medical or genetic risk factors or prior adverse pregnancy outcomes, referral to specialists for various obstetric, fetal, medical or surgical complications, intrapartum consultations resulting from complications of labor or delivery, and referral to appropriate consultants for ongoing management of complex issues in the postpartum state.6 However, caring for the
unborn fetus with anomalies is often even more challenging. Numerous management questions, from ethical to surgical to logistical often plague not only the treatment team but also the parents whose lives will be forever changed by their interactions with the team. A Multi-D approach involving MFM, neonatology, various pediatric surgical subspecialists, cardiology, anesthesiology, palliative care, social work, case management, and various institutional support staff members is often assembled to care for complex cases. Multi-D team care is now routinely employed across the United States for certain birth defects, such as cleft lip with or without cleft palate. Although there is literature regarding the effectiveness of Multi-D team approaches regarding outcomes, little is known about the attitudes and opinions of health care providers toward the Multi-D care they provide. The purpose of this study was to assess the attitudes and opinions of health care providers routinely involved in a Multi-D team care model within a private practice setting at a high-volume community hospital.

Materials and Methods

In 2014, a monthly Multi-D perinatal care conference (PCC) was established at St. David’s Women’s Center of Texas (large community hospital in Austin, TX) by the private MFM and neonatology practitioners. The conference structure consists of (1) presentation of new fetal anomaly cases by MFM providers from Austin MFM (first 20 minutes), (2) presentation of complicated neonatal cases and follow-up of previously presented fetal cases by neonatology (second 20 minutes), and (3) review of impending high-risk maternal cases requiring Multi-D care by other specialties including anesthesiology, cardiology, and social services (last 20 minutes). The invitations to attend were provided to medical staff within the St. David’s Healthcare system, as well as pediatric subspecialists within the immediate market. Invitation to view the conference via the web was provided to referring practices and within the immediate market. The monthly PCC averaged 51 participants per meeting from inception in 2014 through July 2015 when the survey assessment was sent to participants. Of the invitees, 42 (82.3%) responded to the survey. The participants included 11 physicians (26%), 15 nurses (35.7%), 14 sonographers (33.3%), and 2 individuals self-reported as other in terms of job title (4.8%). In terms of age of respondents, 14.3% were between 21 and 30 years, 38.1% were between 30 and 40 years, and 47.6% were 40 years or older. To avoid skewing the perception of the participants, the organizing MFM and neonatology providers were excluded from the survey as they actively participated in the organization and presentation of the conference on a regular basis.

A majority (64.3%) of respondents answered that they strongly agree with the statement “Patients/clients receiving interprofessional care are more likely than others to be treated as whole persons.” No respondents disagreed with that statement. When considering statements regarding the time and resources required to plan interprofessional care team processes, respondents’ answers were more diverse, with 21.4% strongly disagreeing with the statement, “Developing an interprofessional patient/client care plan is excessively time consuming,” 47.6% disagreeing with the statement, 7.1% agreeing with the statement, and another 7.1% strongly agreeing with the statement. However, most respondents (78.6%) either disagreed or strongly disagreed that “In most instances, the time required for interprofessional consultations could be better spent in other ways.” Respondents also reported significant job satisfaction in interprofessional approaches, as 88.1% of respondents either agreed or strongly agreed that “Working in an interprofessional environment keeps most health professionals enthusiastic and interested in their jobs.”

Respondents tended to agree that efficiency of care was improved with interprofessional approaches—92.2% of respondents either agreed or strongly agreed that “the interprofessional approach makes the delivery of care more efficient.” In addition, all respondents either agreed or strongly agreed that interprofessional care helps decrease medical errors, with 66.7% of respondents strongly agreeing and 33.3% of respondents agreeing with the statement, “Developing a patient/client care plan with other team members avoids errors in delivering care.” Respondents also largely felt that interprofessional care was not overly complex in nature, with 90.2% of respondents either disagreeing or strongly disagreeing with the statement, “Working in an interprofessional manner unnecessarily complicates things most of the time.”

When considering the impact of interprofessional care plans on the emotional and financial needs of patients, 52.4%
of respondents agreed and 33.3% of respondents strongly agreed that “Health professionals working as teams are more responsive than others to the emotional and financial needs of patients/clients.” Likewise, respondents largely agreed that interprofessional care plans transcend patient care to also address the needs of family members and caregivers—50.0% of respondents agreed and 38.1% of respondents strongly agreed with the statement, “The interprofessional approach permits health professionals to meet the needs of family caregivers as well as patients.”

Multi-D care also enhanced respondents’ understanding of other health care professionals’ roles within the care team. Thirty-one percent of respondents agreed and 64.3% of respondents strongly agreed with the statement, “Having to report observations to a team helps team members better understand the work of other health professionals.” When considering the transition from hospital care to home following discharge, 31.0% of respondents agreed with and 50.0% of respondents strongly agreed that, “Hospital patients who receive interprofessional team care are better prepared for discharge than other patients.”

Respondents had similar views with regard to communication within interprofessional care teams, with 31.0% of respondents agreeing and 64.3% of respondents strongly agreeing that “Team meetings foster communication among team members from different professions or disciplines.” The last two questions were added to the instrument to assess respondents’ opinions related to the PCC specifically. The majority of respondents believed that the conference achieved its primary goal, as evidenced by 88.0% of respondents either agreeing or strongly agreeing with the statement, “The PCC is achieving the goal of creating a more complete approach to managing the care of our patients.” Finally, respondent answers suggested that the vast majority consider interprofessional team approaches to be associated with aggregate increases in medical knowledge, with 33.3% of respondents agreeing and 64.3% of respondents strongly agreeing with the statement, “The PCC is improving my medical knowledge.”

Discussion
Our survey of providers who regularly attend our monthly PCCs revealed many positive attitudes and opinions toward interprofessional care of the maternal–fetal dyad. Providers’ responses suggested that the time spent involved in interprofessional care among health care providers involved in a monthly PCC believe Multi-D care approaches to be effective, pragmatic, and may result in improved patient, family, and provider satisfaction. Although compelling for the implementation of a Multi-D care approach to complex maternal–fetal patients, our results should be taken in the context of our single-site institution, relatively small sample size, and lack of preimplementation assessment. Future research should include an assessment of the effectiveness of a Multi-D team approach from a patient and patient-family perspective. The creation of a standardized tool for assessing the effectiveness of a Multi-D team approach will hopefully assess the true goal of optimal and complete patient care.

Conflict of Interest
The authors report no conflicts of interest.

Financial Support
There was no financial support for this study.

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