EXECUTIVE SUMMARY – 2009 RMI SNAPSHOT EVALUATION

The Rural Maternity Initiative Evaluation Project of 2007 reported on the outcomes of the Initiative. Given the importance of birthing services in rural areas and the governments ongoing commitment to midwifery models of care it was decided in 2008 to snapshot where each of the projects were in relation to their development and ongoing issues.

All 19 sites originally funded have been included. As in the initial evaluation, we found that comparisons were difficult due to the variation of type of care between services. Models of care had been in operation for a duration of 8 months through to five years and ranged from pregnancy care only to caseload midwifery.

Births increased by 12% in 2 years through the models of care.

All 19 models are now in full operation. 4 were different to that originally implemented, having evolved and developed to better meet the needs of consumers

Relationships between doctors and midwives were much improved with a noticeable increase of trust and respect a common theme. The overwhelming feedback in relation to the Medical Practitioners was that the implementation of the model, no matter what type, had improved their workload in relation to maternity care, particularly the on call and call back requirements within rural settings. Services and doctors reported that work/life balance had improved.

Whilst the initial evaluation showed little impact on recruitment and retention of midwives, most services now reported that the models of care were having a significant positive impact on recruitment and, in particular, retention. Importantly 4 services were now able to employ postgraduate student midwives which they reported had a number of positive flow on effects on their midwifery workforce.

Women continue to be extremely satisfied with the service provided. An increase in access by women from lower socioeconomic backgrounds was noted, along with improved relationships between women and "their" midwives.

Clinical outcomes for women and babies remains as good or better than prior to implementation with no adverse events reported.

None of the services reported issues around the model costing more, with all of them saying they had come in, on or under budget. Most services cited the support of the Rural Maternity Initiative funding as vital to their establishment and ongoing sustainability, particularly in relation to ante natal care.

Commitment, good will, communication and team work were the major themes reported by services as contributing to ongoing sustainability. Major inhibitors for sustainability were community misconception and lack of understanding and information by both community members and some medical practitioners not working in the models.

Three years on it would appear that the projects funded through the Victorian Rural Maternity Initiative have been successful in demonstrating birthing service sustainability in rural areas.

There have been demonstrated workforce improvements in team work and team relations. The service change process has resulted in increased confidence of the workforce and service system in their ability to change service configurations to match their available resources and meet community needs. Information sharing remains an ongoing issue.

Introduction

In 2002, the government committed $4M under the Rural Maternity Initiative (RMI), to the enhancement or development of midwifery models of care within rural health services.

The Rural Maternity Initiative Evaluation Project reported on the outcomes of the Initiative in 2007. Given the importance of birthing services in rural areas and the governments ongoing commitment to midwifery models of care it was decided to snapshot where each of the projects were in relation to their development and ongoing issues.

The primary objective was to gain an understanding of each services progress and their understanding of:

- Women's level of satisfaction with the model of care implemented
- Health care providers' level of satisfaction with the model of care implemented
- The clinical outcomes of the models of care
- The costs of the new continuity models
- Issues that have either strengthened or weakened their models

This report contains information gained through one on one interviews with each of the services originally included in the initiative. All 19 sites originally funded have been included.

PROGRAM INFORMATION

There were a total of 1421 births through the new models of maternity care in 07/08, an increase of 161 babies since 2007. (Table 3, Appendix)

Models of care had been in operation for a duration of 8 months through to five years and ranged from pregnancy care only to caseload midwifery. (Table 1, Appendix) 16 of the programs reported they were still operating under the originally intended model. 4 were different to that originally implemented. Of these one was not fully implemented until February 2008, although they had maintained some pregnancy care in the interim. One had become accessible only to women meeting low risk criteria. Another changed the way in which care was delivered to socially disadvantaged women by streamlining care through the established hospital model with additional midwives and social workers allocated to this group. The final service model had become midwife led care as medical cover had ceased in this community. (Tables 1 & 2), Appendix)

The major issue sited in relation to none or partial implementation of the service model was role clarification for members of the team.
As in the initial evaluation, we found that comparisons were difficult due to the variation of type of care between services.

Adverse Events or Near Misses

Of the 19 services surveyed none reported an adverse or near miss event in relation to their change of practice.

Although all models commenced with what they believed were appropriate guidelines and policies, 8 services changed processes and strengthened guidelines after implementation.
This was:

- to improve practice management and strengthen risk management
- to achieve greater clarity around the level of risk they would accept and
- to clarify of roles and responsibilities within the team.

All services stated they felt they now had stronger guidelines and policies to manage risk than prior to the implementation of the new model. Several stated they managed risk better within the team than prior to the new model.

Clinical Outcomes
Eight models noted measured improvements in some aspects of the clinical care for women being cared for within the models.
These included:

- less use of analgesia
- increase in intact perineum – an extremely important issue to women as noted in the initial report.
- decreased rates of induction and intervention
- decreasing emergency transfers

Among outcomes one service reported a reduction in caesarian section rates from 35% to 13%.
No service reported worse or deteriorating clinical outcomes.
Even those models incorporating only a different antenatal care component reported improvements.
Length of stay was noted as decreased in four models. One service however was an exception, stating that the mothers were "spoilt" and therefore the length of stay had not decreased.

Relationships between Doctors & Midwives
All models reported good working relationships between team members currently. The vast majority reported much improved working relationships than prior to the model implementation..
They had experienced a gradual increase in trust and respect between members of the team over time, particularly an increase in respect for the Midwives skills. The remainder reported already good relationships had continued
Only two of the models were still having some issues but these appeared to be minor and lessening with time.

Midwife perceptions
Three services were reporting some lingering issues between midwives working in and outside of the models introduced. Despite this all services reported an improvement of relationships over time. The majority of services had recruited midwives from the traditional care programs. There was an indication that there was a lot more acceptance of the new way of working being better for women and that even if midwives did not want to work in the model, they supported the change in practice.

Recruitment & Retention
The majority of services reported an improvement in both recruitment and retention of midwives.
Two services faced closure of their birthing service had they not changed the way maternity care was delivered.
Four services now employed post graduate students within their birthing model which had not been possible before.
One midwife had come out of retirement to participate in the new service.
No services reported any issues with retention of midwives working in their new models. One service was still reporting problems recruiting the type of midwife required.
One service was reporting that prior to introduction they had been unable to fill rosters but since implementation they now have a full complement of midwives.
Most services reported an increase in job satisfaction as the major reason for higher retention rates.
One service reported midwives as saying they would leave the service if the model were to revert to the previous way of working.

Medical Practitioners
The overwhelming feedback in relation to the Medical Practitioners was that the implementation of the model, no matter what type, had improved their workload in relation to maternity care. Particularly the on call and call back requirements within rural settings.

In some rural settings the incorporation of the ante natal components into the maternity service had also freed medical practitioners up to do other things. One health service reported that the medical practitioners were now more willing to go on leave and have a break. One doctor talked about his reinvigorated interest in maternity care. Yet another had undertaken studies in ultrasonography to value add to the overall service provision.
Only two services were reporting on going issues with medical referral, however the models were still continuing with women self referring.
The vast majority reported having an increase in respect for midwives skills and an increased confidence in their ability to respond without a medical practitioner needing to be present. In addition it was felt that relationships between team members had greatly improved since the implementation of the new models.
All services except two reported an increase in skill sets and a willingness and acceptance to attend inter professional education for a. A number reporting the midwives had been invited to education previously only for medical practitioners.
The stability of the midwifery workforce in the new models was sited as a plus by some medical practitioners.
Several commented that they enjoyed being needed when they really were needed. There was an overwhelming feeling in the comments of increased support from and for the new models.

Consumers "Women love it"
Overall consumer satisfaction was perceived as extremely positive. 10 services had completed formal evaluations of consumer perception. A number of services noted that women were travelling from outside of their area to access the different model.
One service noted an increase in access to timely ante natal care for women from lower socioeconomic backgrounds. In addition women booked within this model in order to access a midwife only birth. Comments received included "really liked knowing my midwife".
There were some comments relating to community perceptions. There appears to still be a community perception in some areas that it is risky to have a baby in this way.

Model Sustainability
<u>Financial / Cost effectiveness</u>
None of the services reported issues around the model costing more, with all of them saying they had come in, on or under budget. There were reductions in some major costs such as on call and recall costs. In addition the majority reported a decrease in interventions which has naturally meant a reduction in goods and services. There were also savings in bed day costs as the length of stay decreased.

Most services cited the support of the Rural Maternity Initiative funding as vital to their establishment and ongoing sustainability, particularly in relation to ante natal care.

<u>Resource Management</u>
There were several comments in relation to the EBA and the rostering of staff as being a disincentive and that it constrained their ability to offer continuity.
Some models had issues with succession planning especially given that this was a new way for some midwives to be working. As a result access to local midwives who could just step in was limited.

<u>Core features for strengthening & inhibiting ongoing sustainability.</u>
Commitment, good will, communication and team work were the major themes reported by services as contributing to ongoing sustainability. In addition leadership and executive and health service support, along with respect within the team of each others roles.
There was discussion of risk and decision making frameworks as supporting ongoing service delivery, as well as demands from women to have this type of experience.

Major inhibitors for sustainability were community misconception and lack of understanding and information by both community members and some medical practitioners not working in the models.

Several services cited the negative public campaign by the AMA as making progress more difficult as it did not support them continuing.

In addition other inhibiting workforce issues cited were:

- The future for students and their training and consolidation
- Availability of midwives and
- Continuing with mixed models ie. Where midwives work within an acute service having to do nursing work as well as midwifery

Conclusion
Three years on it would appear that the projects funded through the Victorian Rural Maternity Initiative have been successful in demonstrating birthing service sustainability in rural areas.
Clinical outcomes have either remained the same, or improved, with no disruption to service costs.

In addition there have been demonstrated workforce improvements in team work and team relations. Midwives and doctors appear to be more satisfied and comfortable with their work and their work life balance.

The service change process has resulted in increased confidence of the workforce and service syste. Particularly their ability to change service configurations to match available resources and meet community needs. There is a sense of stability and a perception of an ability to redefine as circumstances change.

Consumers were more than satisfied with their care and the options available.
There still remains a perception in the general community about the necessity or otherwise of the presence of a medical practitioner when birthing.

As in the evaluation undertaken in 2007 information sharing is still ad hoc and discordant around the types of strategies each service is using to counter service delivery issues. With no ongoing formal statewide framework yet in place, services struggle to resource the innovation required to maintain high level best practice service models. At best this leads to service duplication, at worst service gaps.

APPENDIX ONE – TABLULATED DATA

Table 1.

Model Implementation

Service	Month / Year Commenced	Total Length of time in operation
Alpine Health	February 2006	3 years
Ballarat Health Services	October 2005	3 & 1/4 Years
Bass Coast Health Service	May 2003	5&1/2 years with a six month closure in 2008 due to lack of midwives working within the model. Pregnancy care continued during this time.
Benalla & District Memorial Hospital	March 2005	3 & 1/2 Years
South West Health Care Camperdown	May 2007	18 months
Western District Health Service (Hamilton)	May 2006	2& 1/2 Years
Wimmera Health Service (Horsham)	May 2006	2 & ½ Years
The Kilmore & District Hospital	2005	4 Years
La Trobe Regional Health Service	January 2008	1 Year
Orbost Multipurpose Service	October 2005	3 ½ years
Portland & District Hospital	2004	5 Years with a cessation of service between October 2008 & January 2009 due to lack of medical support in town.
Seymour District Memorial Hospital	November 2005	3 & ¼ years
St Arnaud	July 06	2 & ½ Years
Terang	May 2006	2 & ½ Years
Timboon	January 2007	2 Years
East Wimmera Health Service	January 2007	2 Years
Rural North West Health Service	April 2007	1 ½ years
South West Health Care - Warnambool	May 2006	2 ½ years
West Gippsland Health Service (Warragul)	2004	5 Years
Yarrawonga & District Health Service	March 2006	2 & ¾ Years

Table 2
Type of Maternity Care Model
(M) = Modified

Service	Caseload (M)	Shared Care Collaborative	Other	Same as Originally Implemented
Alpine	*			Yes
Ballarat	Primary MW Care			Originally included women in all risk categories, now only low risk due to decrease midwife EFT
Bass Coast			Team Maternity	Yes
Benalla		*		Yes
Camperdown		*		Yes
Hamilton			Team Maternity	Yes
Horsham			Team Maternity	Yes
Kilmore		*		Yes
La Trobe Regional			Special Needs Outreach Midwife	No
Orbost			Team Maternity	Yes
Portland	*M			Yes
Seymour			Commenced with pregnancy care only but moved to shared care collaborative in February 2008	No
St Arnaud			Pregnancy Care	Yes
Terang		*		Yes
Timboon	Midwife Care			No
Warracknabeal			Pregnancy care	Yes
Warnambool	*M			Yes
Warragul	*M	*		Yes
Yarrawonga		*		Yes

Table 3
Birth Numbers

Service	Total Births for Organisation 07/08	Total Women through Model 07/08	% change from previous year
Alpine	50	42	4% decrease
Ballarat	1192	140	-
Bass Coast	170	170	13
Benalla	118	118	unknown
Camperdown	66	30	—1st yr
Hamilton	222	11	44% decrease*
Horsham	365	71	15% decrease
Kilmore	214	214	No change
La Trobe Regional	944	100 (capped)	Availability to women determined by EFT
Orbost	35	35	10.5% decrease
Portland	115	115	unknown
Seymour	0	112	Need to check this
St Arnaud	4	90 (3 births)	Increase in pregnancy care visits, one more birth during this period.
Terang	50	50	9% increase
Timboon	39	39	1st year
Warracknabeal	0	12 (0 births)	1st yr
Warnambool	600	120	2% increase Availability to women determined by EFT
Warragul	817	97	Combined shared care collaborative and midwife led care numbers. Change in numbers unknown.
Yarrawonga	80	80	31% decrease in birth numbers – reasons as yet unknown.
Total births in model		**1421**	