

**Creating Change in Early Prenatal Care Entry: A Peer Learning Conversation April 9,
2014
3:30-5:00pm EDT**

Ensuring women receive prenatal care in their first trimester is vitally important to supporting healthy mothers and babies. As a required Uniform Data System (UDS) measure for federally qualified health centers (FQHCs), it is a priority for HRSA and health centers, particularly as part of a patient-centered medical home. However, health centers inevitably face challenges in achieving this goal. This peer learning call, presented by the National Academy for State Health Policy (NASHP) in collaboration with the HRSA, sought to address challenges by providing a unique opportunity to:

- Learn about promising practices and hear from three featured FQHCs who are high performers in early prenatal care entry;
- Participate in a small, supportive group conversation with peers across the country;
- Identify action steps for continuing to make strides in improving early prenatal care entry.

To allow for rich conversation among participants, registration was limited to teams from 15 health centers. We hope these notes will succeed in sharing key discussion points and lessons from this call with health centers around the country.

ATTENDEES

- Moderator: Catherine Hess, MSW, Managing Director for Coverage and Access, NASHP
- Health Resources and Services Administration (HRSA)
 - Preeta Chidambaran, MD, MPH, Medical Officer, Office of Quality and Data, HRSA Bureau of Primary Health Care
 - Sabrina Matoff-Stepp, Ph.D., Director, HRSA Office of Women's Health
 - Bethany Applebaum, MPH, Public Health Analyst, HRSA Office of Women's Health
- Featured Health Centers
 - Allison Foley, RNC, MS, Women's Health Nurse Practitioner, Harbor Health Services
 - Rebecca Corpuz, Deputy Director, Seattle Indian Health Board
 - Joelle Mauthe, RN, Seattle Indian Health Board
- Participating Health Centers:
 - Open Door Community Health Centers, Arcata, CA
 - Jessie Trice Community Health Center, Miami, FL
 - Community Health Center of Southeast Kansas, Pittsburg, KS
 - CAMCare, Camden, NJ
 - La Clinica de Familia, Las Cruces, NM
 - Middletown Community Health Center, Middletown, NY
 - East Texas Community Health Services, Nacogdoches, TX
 - Heart of Texas Community Health Center, Waco, TX
 - Nuestra Clinica Del Valle, San Juan, TX
 - Esperanza Health and Dental Centers, San Angelo, TX
 - Southwest Utah Community Health Center, St. George, UT

WELCOME & INTRODUCTIONS

- **Catherine Hess, NASHP:** Welcomed attendees and summarized the call agenda.
- **Preeta Chidambaran, HRSA Bureau of Primary Health Care:**
 - Early prenatal care entry is an important UDS measure to ensure quality care for mothers and babies. HRSA wants to promote early prenatal care entry within context of the patient-centered medical home (PCMH).
 - The Healthy People 2020 goal for early prenatal care entry is 77.9% by 2020. Overall 2012 rate for FQHCs is 70.2%. There is a wide range in early prenatal care entry rates along health centers – from 100% to 3%. HRSA seeks to narrow this range and improve early entry rates for all health centers, and support efforts toward that goal. This call is a great step toward this effort!
 - Thanks to all the health center grantees who have called in, featured FQHCs, NASHP, and HRSA's Bureau of Primary Health Care, Office of Women's Health, Maternal and Child Health Bureau, and more!
- **Catherine Hess, NASHP:** This project is part of a cooperative agreement with HRSA to support partnerships between safety net providers and Medicaid. NASHP researched practices that support early prenatal care entry at FQHCs, looking at UDS data to identify 10 high-performing FQHCs across the country in four high-performing states. NASHP looked at health center policies and practices through a PCMH lens, focused on 6 domains (see notes). Will also mention some other products later in the call.

FEATURED GRANTEEES

- **Harbor Health Services** – Allison Foley is a women's health nurse practitioner at Neponset Health Center, one of Harbor Health Services' three clinics located in Dorchester, Mattapan, and Massachusetts's South Shore. Harbor Health has a number of departments, including a small women's health department. Harbor Health Services serves 11,000 patients/year, including approximately 288 prenatal patients/year. Harbor Health Services' patient population is approximately 40% White, 30% Asian, 20% African American, 10% other. Over the past few years, Harbor Health has increased early prenatal care entry rates by about 10%.
- **Seattle Indian Health Board** – Rebecca Corpuz, Deputy Director, has been at Seattle Indian Health Board for 40 years, and Joelle Mauthe has been a nurse at the health center for 35 years. Seattle Indian Health Board is located near downtown Seattle, Washington. Its target patient group is American Indians and Alaska Natives in the Seattle area and broader King County, Washington. Approximately 34,000 Native Americans live in the Seattle area; Seattle Indian Health Board sees about 10,000 patients per year for medical, dental, behavioral health, and community services (including elder, veteran, youth, and domestic violence programs), including 150-200 prenatal patients/year; 70% are Native, about 30% are mixed race. Approximately 93% live below 200% FPL. As of 2013, 60% were uninsured – this is now changing as more enroll in coverage under the Affordable Care Act.

Q&A WITH FEATURED HRSA GRANTEEES

What short-term changes (<1 year) has your health center made to improve early prenatal care entry?

- **Harbor Health Services:**
 - *Protocol Changes:* About two years ago, Harbor Health revised policies around pregnancy testing and prenatal care policies to increase rates of early entry. The new policy specifies that each patient who expects she is pregnant will meet with a provider (most likely a nurse practitioner) within two days to confirm, start prenatal vitamins, get in touch with social and community services, review medications, set up her next visit, and receive counseling around healthy pregnancies. Harbor Health Services revised its prenatal policy to include specific timelines for visits: around 9 weeks for prenatal intake (includes prenatal lab work, genetic screening, ultrasound referrals); and before 13 weeks for a formal first prenatal visit with a provider that includes a physical. This was an easy change once Harbor Health revised the policy and educated staff, and was implemented relatively quickly.

- *Quality Steering Committee:* Harbor Health Services has a Quality Steering Committee to drive continuous quality improvement efforts at the health center. Each department selects a measure on which to focus; in 2012, the health center's women's health department chose early prenatal care entry. Women's health department staff used data from the health center's Electronic Medical Record (EMR) to track performance and measure improvement.
- *Pregnancy Testing Policies:* Harbor Health Services sees patients for pregnancy testing regardless of insurance coverage or ability to pay. Patients are referred to on-site financial counselors as soon as pregnancy is confirmed to see if they're eligible for Medicaid or other state programs, which gives the patient and the health center time to get coverage in place before the 9-week visit. Harbor Health also has several patient navigators and financial counselors on staff, which has been very helpful for patients.
- **Seattle Indian Health Board:**
 - *Pregnancy Testing Policies:* Seattle Indian Health Board has similar policies around pregnancy testing. Walk-in, same-day appointments are available for women who suspect they may be pregnant. Patients start prenatal vitamins and undergo prenatal intake as soon as possible, often before 9 weeks, so that referrals to other services or providers can begin early. Seattle Indian Health Board does not wait for insurance coverage to test for pregnancy or begin prenatal intake.
 - *Prenatal Thursdays:* Each Thursday, the health center makes providers available to see prenatal patients for pregnancy testing and early prenatal visits, including a pharmacist, nutritionist, and breastfeeding educator. Health education is also available to patients and their partners on a walk-in basis, and the health center serves lunch to clients.
 - *Patient Education Materials:* Seattle Indian Health Board has also created a brochure used at community events to educate patients about prenatal care services offered at the health center. Materials are often distributed at cultural and community events where many American Indians and Alaska Natives gather.
- **Participating Health Centers:**
 - *Group Prenatal Welcome Visits:* One health center struggled to find providers and space to quickly schedule early prenatal care appointments for newly pregnant women, as well as to break up long initial appointments. The health center has started doing a group prenatal welcome visit prior to the initial exam, including an hour-long presentation by a nurse or health educator to educate patients about the practice, discuss basic pregnancy information and what to expect, and complete initial paperwork. Patients receive educational materials on issues such as prenatal appointment schedules, labs to be drawn, prenatal screening tests that are time sensitive, the health center's call system/how to reach providers, dietary changes, community resources, and relevant state programs. The health center has found that this is a helpful way to connect patients early in pregnancy.

What changes took longer to implement?

- **Seattle Indian Health Board:**
 - *Case Review Meetings:* Seattle Indian Health Board has implemented weekly team meetings to review caseload and patient needs, including nutritionists, prenatal staff, docs, nursing staff. Family practice residency program helps with deliveries as well, and are part of this team.
 - *EMR Implementation:* EMR implementation has taken longer, but has also helped track when patients enter care, as well as outcomes like birth weight. Health center staff review data at the end of the year, but haven't started tracking day-to-day yet. EMR also helps Seattle Indian Health Board track physical patient movement. The health center's patient population is very mobile seasonally for seasonal work, fishing, cultural events. Prenatal data entry includes information on the number of people who enter prenatal care entry program, as well as whether patients continue prenatal care with Seattle Indian Health Board and where patients deliver. In 2013, about half chose to deliver elsewhere (on reservation, in a seasonal community), but many come back to Seattle Indian Health Board for baby care and to receive ongoing care.

- **Harbor Health Services:**
 - *EMR Implementation:* Using EMR to track prenatal data has been Harbor Health Services' biggest challenge – it is helpful now, but has taken a long time to get there. Harbor Health switched to EMR health center-wide in 2007, but only brought the EMR into prenatal care in 2009 or 2010. Providers are still learning how to capture the right data in right places, but accuracy is improving over time. Harbor Health uses the EMR to track similar things – How many prenatal patients receive care at the health center? Are there inconsistencies? Who hasn't been coming in? Which pregnancies have ended? – as well as to track outcomes of interest like low birth weight and early prenatal care entry rate at the end of the year.
 - *Provider Pay-For-Performance Program:* Harbor Health Services has implemented a pay-for-performance program for health center providers. Process and outcome measures like early prenatal care entry rates and low birth weight, as well as EMR use, are measured on a quarterly basis (as well as other measures) and impact salary increases and decreases, a helpful incentive for providers. This program has been in place for a few years, and has highlighted the challenges of inconsistent EMR use and data entry,
 - *Perinatal Collaborative:* Harbor Health Services developed an internal perinatal collaborative ~2 years ago with representatives from the health center's women's health department, on-site Women, Infants, and Children (WIC), pediatrics, social services and behavioral health – everyone who supports early prenatal care entry. The collaborative meets once per month to discuss cases and develop programming and initiatives to improve perinatal care outcomes.
- **Participating Health Centers:**
 - *Group Prenatal Visits:* What are health centers' experiences with group prenatal visits? Have health centers seen impacts on patient compliance and outcomes?
 - Health centers reported mixed experiences with group prenatal visits.
 - One is interested in implementing group visits within the next year, using the Centering Pregnancy model. This model is just starting out in this health center's region – the health center is now interviewing other community health centers in the area that are using this model. It has not received great feedback so far, but is trying to move in that direction.
 - Another health center previously used the Centering Pregnancy model. The program was not popular among the health center's prenatal patients, many of whom are Spanish speaking and uninsured, and ended after two years. Many have a close knit family community and felt like community and family support for pregnant women was already there; patients wanted one-on-one visits with providers. Group visits do have some nice advantages – the health center is looking for a way to recapture important parts of that model.

What state policies, programs, or assistance – from Medicaid, Maternal and Child Health Officers, Primary Care Offices, or others – have contributed to your high performance?

- **Harbor Health Services:**
 - Health centers in Massachusetts are lucky to have had easy access to insurance coverage for patients since state health reform went into effect. Patients' initial pregnancy testing visit is funded through a state family planning services grant if the patient is uninsured. In addition, a financial counselor can fill out enrollment forms for Medicaid and other state programs for patients through the Virtual Gateway, an online tool available in Massachusetts. Harbor Health Services has interpreters on-site for Vietnamese speakers (about 30% of patients). An on-site case manager, funded by a state grant through Tufts Medical Center, encourages healthy pregnancies and kids.
- **Seattle Indian Health Board:**
 - A now-defunct Maternity Case Management Program for Medicaid-eligible patients provided eligible patients with case management services, supported them in applying for insurance coverage, and connected patients with community resources and social services.

OPEN DISCUSSION WITH PARTICIPATING HEALTH CENTERS

What are primary challenges to improving early prenatal care entry rates, and how can health centers address them?

- *Timing of Early Prenatal Visits:* One health center reported challenges in trying to figure out the right timing for prenatal care entry and initial testing. A local women's health program does only pregnancy testing and prenatal care, and the health center has struggled to navigate the overlap. Some patients come to the health center for initial tests and major lab work but go to other programs for prenatal care. What to do when, and how? How does that translate to clinical protocols?
 - Another health center described their protocols for timing prenatal intake and early prenatal visits: When women suspect pregnancy, they can call the health center and make appointment with any provider, usually a nurse practitioner – the health center does not have family planning counselors. Women with positive pregnancy tests are transferred to women's health for prenatal care entry. Women come back for a prenatal intake visit between 8-10 weeks to collect a health history, provide health education, and more. Around 11 weeks, women return for an exam and first prenatal visit. The challenge is accommodating initial visits between 8-10 weeks; the health center only has two nurses performing these visits, though it is adding a nurse to accommodate prenatal intake volume. The nurse visit is billable as part of prenatal care global visit.

How does PCMH recognition support improvement on this measure?

- *EMRs:* Health information technology is a big part of the patient-centered medical home. For one health center, using the EMR for prenatal visits has made a big difference in performance and ability to monitor performance. The health center is tracking data more accurately since EMR implementation.
- *Communication with Hospitals:* One health center's OBGYN and Medical Director got online access to the local hospital's EMR; hospital staff can also access the health center's EMR. Rather than copying and faxing charts, charts are updated in real-time. This also helps the community health center get information on birth weight and other outcomes more easily, which contributes to continuity of care.

What guidance, TA, other support from HRSA, state officials, or other partners would help in improving early prenatal care entry rates?

- Participating health centers requested notes from this call.
- Additional calls like these where health centers have opportunities to share experiences.
- In the call evaluation, participating health centers also requested policy and protocol samples from other participating health centers, and contact information for call participants.

What challenges do health centers face related to tracking or reporting data? What solutions have been successful?

- *EMR Implementation:* Providers are used to paper charts with one page of paper with all visits, limited space for notes, and faxes for hospital records; the switch to EMR, where one record can be 28 pages long and include lots of details, is difficult. Health center quality assurance departments prefer additional details and better trackability, but it changes workflow.
 - Another health center experienced the same resistance to EMRs – everyone likes a one-page flow sheet that's easy to navigate. At the end of the day, the health center knew implementation to happen by a certain date and made it happen. The internal pay-for-performance measures helped; EMR adoption was part of the pay-for-performance scale. Providers who were not willing to adopt were being hit in the pocket. Providers will often choose paper if given a choice; the health center chose to make it standard, choose a date, and do training, and found that providers supported each other in making it happen.
- *Patient Retention:* It is also a challenge when patients come in for initial labs and then go elsewhere for prenatal care. The health center often sees this if patients qualify for Medicaid and gain additional options for prenatal care. Patients with immigration issues often fear seeking medical services, including prenatal care, and some will initially pay out of pocket to keep visits out of a chart.
- *Access Barriers:* One health center is currently evaluating barriers to access, and did a "secret shopper" program to learn more about the challenges patients had in scheduling a first prenatal visit.

The health center found that it took many weeks for pregnant women to schedule a first prenatal appointment, and in response implemented an initial visit that includes confirmation of pregnancy – these are scheduled within 1-2 days. Connecting with pregnant women early, providing counseling, identifying risk factors, and providing quality early care have all helped with retention.

Have community health centers found lessons around prenatal care entry for first-time patients who were not previously connected to the health center versus long-time patients? Any lessons learned around adherence, connection to care, etc.?

- One health center has had very good luck with established patients. Some doctors have been serving patients at that health center for many years – many pregnant women are delivered by doctors who may have also delivered their mothers and grandmothers. Patients who were referred by previous patients often come back and refer friends.
- A different health center reports that most established patients seek prenatal care at there as well. Most who come to the health center to confirm pregnancy also stay on for prenatal care, as well as other care after delivery.

CONCLUDING REMARKS AND NEXT STEPS

- **Preeta Chidambaran, HRSA Bureau of Primary Health Care:** This was a great call, with many good points. It's great for HRSA to know that health centers have interest in more calls like these. Thanks to health centers for taking the time to attend!
- **Catherine Hess, NASHP:** Summary notes will be shared with participants.
 - Other resources produced through this project:
 - §§ *HRSA Grantee Spotlights:* Grantee Spotlights are short, blog-style posts on the HRSA Bureau of Primary Health Care website that highlight promising health center practices. A Grantee Spotlight featuring Erie Family Health Center's women's health promoters is already published (<http://bphc.hrsa.gov/spotlight/eriefamilyhc/index.html>). A second Grantee Spotlight featuring Harbor Health Services is coming soon.
 - §§ *Fact Sheet and Chart:* A fact sheet and chart highlighting promising health center practices and state policies that support early prenatal care entry are planned for June.
 - §§ *National Webinar:* A national webinar on supporting early prenatal care entry will feature speakers from two health centers and two state officials interviewed for this project; the webinar will be aimed at FQHC and state audiences.
 - §§ *NASHP's Access and the Safety Net Webpage:* NASHP's Access and the Safety Net webpage highlights research and products from all of NASHP's work around safety net issues. Visit the site at: <http://www.nashp.org/access-and-safety-net>.