Women’s Health Services at UNHS: Increasing Patient Education and Provider Knowledge of Supportive Community Resources

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Introduction:

The Problem:

Vanderbilt University’s 2009 Health Report Card gave Tennessee’s women failing grades in every indicator of reproductive/sexual health and modifiable risk factors. Although the 2013 Health Report Card showed marked improvements in some areas, health disparities remain evident in Tennessee’s minority and low-income female populations. The Tennessee Department of Health has initiated efforts to address these significant disparities; however limited resources, failure of the state to expand Medicaid, and rapidly expanding uninsured immigrant populations pose significant challenges. Community clinics such as the United Neighborhood Health Services family clinics are therefore vital to provision of quality and accessible care, especially for women.

Intervention Support:

Indicative measures of women’s health comprising the Nashville Women’s Health Report Card include: reproductive health, sexually transmitted infections, causes of death, modifiable risk factors, preventive health, and barriers to health care. Although all measures of reproductive health declined across all races, African American women consistently had higher percentage of very low birth weight babies, births to women under age 18, and infant mortality, and shorter intervals between births than both white and Hispanic women. African American women received failing scores in three of the five markers of reproductive health as compared to one failing score each (percentage of women who smoked during pregnancy) for both white and Hispanic women. Most concerning, although the 2010 National infant mortality rate was 6.15 per 1000 live births (CDC.gov), the 2011 Infant mortality rate for all women in Tennessee was
approximately 7.4 per 1000 live births. This rate above the National average appears to be skewed due to significant differences in infant mortality among White, Hispanic, and African American women with rates of 6.0, 5.1, and 12.8 per 1000 live births respectively. (Vanderbilt Institute 2013) Additionally, the Tennessee Pregnancy Risk Assessment Monitoring System (PRAMS) 2009 summary reported one-half of all pregnancies were unintended which reflects under-utilization of contraception in women not trying to conceive. Further, 67% of surveyed mothers did not receive any preconception counseling and nearly one-fifth received late or no prenatal care. (Law, Rico and Bauer)

African American and Hispanic women fared equally with three failing scores in rates of sexually transmitted infections, while White women received top marks in each of the four categories. Of note, differences in chlamydia and gonorrhea infection were significant among the races. Although rates of chlamydia increased in both African American and White women between 2006 and 2011, there was a dramatic difference in overall rates among these groups. Rates of chlamydia increased from 253.9 to 363.0 per 100,000 White women, as compared to an increase from 1764.9 to 2675.6 per 100,000 African American women. Rates declined slightly in Hispanic women, 1614.2 to 1087.1 per 100,000, however these rates remain significantly higher than those of their white counterparts. Similarly dramatic differences are seen in rates of gonorrhea infection, the only category where African American women received a score of “F” while “All”, “White”, and “Hispanic” women were give an “A” score. Rates of gonorrhea infection decreased for all women from 197.9 per 100,000 in 2006 to 153.9 per 100,000 in 2011 due in part to consistently low rates in white women (54.8 to 35.0 per 100,000) and a decrease in Hispanic women (109.7 to 62.2 per 100,000). During this time period, rates of gonorrhea
infections among African Americans increased from 632.4 to 699.5 per 100,000 women. (Vanderbilt Institute 2013)

Heart Disease (248.9), stroke (70.2), lung cancer (64.2), breast cancer (31.8), and diabetes (31.6), were the top five causes of death per 100,000 African American and White women in 2011 (data for Hispanic women was unavailable). Rates of death were highest among African Americans in all categories except lung cancer. Many risk factors, modifiable by changes in diet, fitness, or preventive screening, such as hypertension, high cholesterol, obesity, diabetes, and smoking may contribute to heart disease and stroke. Although there was a smaller percentage of African American women who smoked (13.1% vs. 22.4% White) or had high cholesterol (39.4% vs. 44.0% White), there was a slightly higher percentage with diabetes (14.9% vs. 10.9% White) and high blood pressure (41.4% vs. 38.5% White). There were also a higher percentage of obese African American women as compared to white counterparts, 47.1% and 27.8% respectively. The high rates of lung and breast cancer may contribute to Tennessee’s ranking as sixth highest in the country for death from cancer. In 2011, only 76.2% of women over the age of 40 received a mammogram, with higher rates among African American women (83.5%) as compared to white women (74.7%). However, the number of clinical breasts exams was consistent around 88% for both groups. Approximately 83.6% of women over the age of 18 had received a pap smear exam within 3 years which may account for the low number of cervical cancer deaths (4.4 per 100,000 women). However, that number did increase slightly from 2006 to 2011. (Vanderbilt Institute 2013) Opportunities to increase screening and preventive health measures in certain populations may account for many of these preventable deaths.

Socioeconomic factors may be significant barriers to accessing quality and timely health care services, and may reflect racial disparities. Although 84% of all Tennessean women have
health insurance, only 50% of Hispanic and 77.9% of African American women are insured, as compared to 86.8% of White women. Further, while 16.7% of Hispanic and 13.3% of African American women were unemployed or looking for work, this affected only 7.6% of White women. This may be reflected by the 32.9% of Hispanic and 27.7% of African American women living below poverty as compared to 14.7% of their white counterparts. (Vanderbilt Institute 2013)

Disproportionately high rates of very low birth weight deliveries, infant mortality, sexually transmitted infections, breast cancer deaths, hypertension, obesity and decreased utilization of preconception and prenatal care services indicate need for continued improvement in outreach, education, and health care delivery targeted specifically to minority women (Vanderbilt Institute for Medicine and Public Health). With many socioeconomic challenges contributing to poorer health, community health centers such as United Neighborhood Health Services (UNHS) are essential to ensure that women in at-risk communities receive quality, timely and accessible care. UNHS has specifically expressed interest in increasing utilization of women’s services including prenatal health and preconception counseling.

United Neighborhood Health Services clinics provide care to residents of Davidson County Tennessee, including the city of Nashville. The 2010 United States Census Bureau reports a population of 601,222 of which 51.5% are female. Nashville-Davidson County is approximately 56.3% white, non-Hispanic or Latino, 28.4% African American, 10% Hispanic or Latino. Although minorities make up a smaller percentage of the population, minority women appear to bear the larger burden of poorer health. Also, nearly 12% of the Nashville population was born outside of the United States and half of that number immigrated to the area within the last 14 years. (2010 US Census) In 2012, Nashville had the fastest growing immigrant population
of any American city and now is home to large Kurdish, Somalian, and Sudanese communities. (Nashville.gov) The large immigrant population poses several challenges to the healthcare system, mainly higher rates of un-insurance, language barriers, and cultural differences.

Currently, UNHS Family clinics are equipped to provide a number of women’s health services including preconception counseling, prenatal care up to 32 weeks gestation, behavioral health services, chronic disease management, and cancer screenings. One year ago, UNHS received a grant from the Centers for Medicare and Medicaid Services (CMS) to institute the Strong Start Prenatal health education program. The primary goal of this program is to reduce infant mortality and low-birth weight deliveries. It targets women in at risk communities, such as the 37206 zip code surrounding the UNHS Cayce and Main Street family clinics. Although the clinics are equipped to provide the care needed, there are currently no women’s health services specific marketing materials, to aid outreach to the community. There are also limited marketing material, and no Strong Start marketing materials, in the clinic lobbies and waiting rooms. Additionally, although there are a number of community resources available for women, there is currently no compiled written resource of information for providers or patients offered in the UNHS clinics.

Proposed Intervention:

The proposed intervention seeks to address the significant health disparities facing minority and low-income women utilizing the UNHS clinic system. It will support efforts to improve women’s health in the Nashville area by assessing the health education needs and interest of female patients seen specifically in the Cayce and Main Street family clinics. Further,
this intervention will provide support for limited financial and staff assets by developing marketing and educational materials specific to women’s health in an effort to provide on-going community outreach, engagement, and education around key health topics. Finally, this intervention will develop a compiled single source of resources available for women in the community for use by both providers and patients to support better overall health.

Methodology:

Key Informant Interviews

To guide project development, key informant interviews were conducted with UNHS Cayce and Main Street clinic staff, clinicians, and community stakeholders. Over the course of six weeks, key informants were identified and interviewed either in person or via phone. Key Informants were selected based on their role and level of interaction with the community. A variety of perspectives were sought to ensure an accurate and complete depiction of the intended population. During week one, the UNHS Health Promotion Coordinator, Strong Start Program Coordinator and two Health Coaches, and Cayce Family Clinic Obstetrician/Gynecologist were selected and interviewed. During week two, A Main Street family clinic Family Medicine Physician was identified and interviewed. Stakeholders from the local department of Public Health were also identified as key informants and scheduled for interview during week three. Finally, the Co-Program coordinator of the Tied Together parenting program at a local community center was identified and interviewed at the end of week two. Three Department of Public Health TENNDer Care employees, representing the Welcome Baby program, youth outreach, and community health divisions were interviewed as community stakeholders during week three. Interviews of UNHS leadership began in week four with the Cayce Family Clinic
Director and UNHS Board president. The UNHS Chief Medical and Chief Executive Officers were interviewed during weeks five and six, respectively. Each Key informant was asked a series of standard questions as well as questions tailored to their role and level of community engagement.

*Women’s Health Questionnaire*

A women’s health needs questionnaire was also developed during week two. See Appendix. Recommendations from public health experts were elicited to ensure appropriate structure and effectiveness. These surveys were distributed with intake paperwork to all female patients seeking care in the Cayce and Main Street Family clinics during weeks three through six. These two clinics were chosen due to the majority English speaking population as translation services were not readily available for the survey. The Tied Together parenting program was identified as a possible resource for the provider/patient women’s health resources brochure. Therefore surveys were also distributed to graduates of the program during an annual alumni reunion event. The survey data was compiled and analyzed using Microsoft Office Excel. The results were then used to guide the intervention.

*Women’s Health Marketing and Education Materials:*

A flyer marketing the women’s health related services at UNHS was created for print and distribution in the family clinics’ lobbies and exam rooms. Health education information was compiled and provided to patients in the form of one page handouts based on the results of the women’s health questionnaire. Finally, a provider’s handout was created which compiled local community resources for women’s health and overall well-being. These resources were
identified and verified via recommendation from clinic staff, internet searches, and United Way’s 211 hotline.

**Results:**

*Key Informant Interviews*

Key informants were asked a series of standard questions and those tailored to their roles and level of community engagement. A total of fourteen individuals were interviewed over the course of six weeks. One hundred percent of the key informants indicated that Tennessee’s failure to expand Medicaid has been the biggest challenge associated with provision of care and overall health for the communities served at UNHS clinics. Other common obstacles included language and cultural barriers, limited financial and staff resources, and lack of communication between national and state agencies responsible for assisting with navigation of the new, online health insurance marketplace. Health care needs identified through these interviews were diverse. Complex chronic disease management, health education and outreach, assistance obtaining health insurance, and more easily accessible translation services were the most common general needs. Increased awareness and utilization of pre-conception counseling and prenatal health services, as well as development of prenatal health education classes were identified as the most pressing health needs specific to women.

*Women’s Health Questionnaire*

The women’s health questionnaire was designed to gain insight into the health needs and interests of the women served by UNHS. Thirty-seven total surveys were collected: ten from the Cayce family clinic, fifteen from the Main Street family clinic, and twelve from the Tied
Together alumni event. Respondents ranged in age from fourteen to over forty-six. Reasons for the clinic visit ranged from routine follow-up and diabetes care to prenatal care and annual exams. See Figure 1.

Figure 1. Reasons for clinic visits.

![Chart showing reasons for clinic visits](image-url)

* Total number of responses is greater than the number of surveys collected in the clinics due to respondent’s ability to choose multiple responses.

Sixty-five percent of all respondents had received an annual exam/Pap smear within the last year, eighty-seven percent within three years. Of the five respondents who had not receive an annual exam/Pap smear in three or more years, three were age 41+, while two were 14-30 years of age.

Seventy-five percent of respondents were either currently or had ever been pregnant, with ninety-three percent of those respondents having received some prenatal care. During their last
pregnancy, 65% of respondents saw their physician for prenatal care one or more times per month. Twenty-seven percent of women saw their physician every 2-3 months while 8% saw their physician only 1 or 2 times before delivery. Of women who were currently or had ever been pregnant, only 46% reported ever being offered any pregnancy related educational materials or classes. Ninety-three percent of these women had never heard of the Strong Start program.

Sixteen of the 27 women who were currently or had ever been pregnant responded to question 10 regarding information that may be helpful before, during, and after pregnancy. Understanding health insurance was important to 38% (6) of respondents while 31% (5) wanted to understand birth control options. Preventing sexually transmitted diseases and understanding what prenatal care is and its importance during pregnancy were equally important to 75% (12) of respondents. Fifty-eight percent thought knowledge of community resources available for pregnant or parenting moms was important. Of all women, 39% expressed some level of interest in participating in free prenatal classes, while 66% expressed some level of interest in attending free monthly women’s health classes or educational workshops held at a local clinic or community center.

Of women who answered question 13 regarding health topics they would like to see presented during the free health education classes or workshops; 71% indicated stress reduction. Both women’s heart health and cervical cancer and breast health were chosen by 58% of women. Weight Control, exercise, and nutrition was an important topic for 50% of respondents. Finally, thirty-three percent were interested in learning more about pregnancy prevention and birth control,

Discussion:
UNHS family clinics see a variety of patients, children to the elderly. These clinics are vital to the health of the lower-income, uninsured, and under-insured as services are offered regardless of the patient’s ability to pay. Because the State of Tennessee did not expand Medicaid after implementation of the Affordable Care Act, the number of uninsured or underinsured increased in Tennessee. Minorities, including the growing immigrant population, were most significantly impacted by the new legislation. Sliding fee scale services and low co-pay options increase accessibility to preventive health care for those who may otherwise delay care or overuse emergency rooms due to un-insurance or an inability to pay for services. Preventive healthcare for women is especially important as it covers a wide range of needs including chronic disease management, preconception health, prenatal care for mother and baby, and other disease prevention measures.

The 2009 and 2013 Vanderbilt University Women’s Health Report Cards indicate that while health conditions are improving in some areas for Tennessee’s women, there is huge opportunity for improvement as effort is made to achieve Healthy People 2020 goals. Most importantly, the data shows that minority women suffer disproportionately from failing grades in key health measures. Health education and community outreach have been successful methods of improving health, especially in low-income and minority populations. In addition to the potential to reach large numbers of potential patients, health education materials such as one page handouts, are inexpensive, easy to reproduce, and a sustainable method of on-going education. Additionally, development of a brief “go-to” resource brochure specific for healthcare providers was supported by dialogue with key informants. Programs and activities from local community centers, public health departments, health facilities, and/or schools may provide the support patients need to be successful. Although there were a number of resources available to patients in
the community, many providers vocalized a desire to have such resources in a compiled, more easily accessible format. The provider’s brochure was designed to be accessible, easily updateable, and sustainable. It may increase knowledge of available resources and assist with ongoing total care of the patient.

**Strengths, Weaknesses, and Limitations:**

Strengths of the intervention are inclusion of multiple stakeholder perspectives, use of a peer and public health expert reviewed surveying tool, and development of useful, sustainable education, outreach, and engagement marketing materials. Further, engagement with key stakeholders to initiate dialogue around implementation of future interventions including the free monthly “Women’s Health Wednesdays” education workshops was also a strength.

There were many challenges to development and implementation of this intervention. The major weakness of this project is the small sample size. Although the sample was comprised of patients from the demographic and geographic area of interest, the sample size may be too small to fully represent the total population. Additional weaknesses include challenges connecting with essential community stakeholders to interview such as patients and local housing authorities. Although there was hope to conduct a focus group with current and potential patients, there were already plans in place for the Strong Start program to conduct a large scale focus group in August. Therefore facilitating another focus group in July was not feasible.

The major limitation to the project was the amount of time on site. Six weeks was a very limited amount of time to identify, develop and implement an intervention. Also, there was no
data from previous assessments of UNHS clinics available to use as a guide for development of
the independent service learning project, or to support the proposed interventions.

**Recommendations:**

Preliminary data from the women’s health questionnaire indicated some interest in free
health education workshops and prenatal health classes. However, the small number of surveys
collected may not be indicative of the entire population. Therefore it may be beneficial to
conduct surveying on a larger scale, including more clinics and surveys in different languages, to
better assess interest. Development of “Women’s Health Wednesdays” free education sessions
held at local schools, community centers, and housing authorities may increase overall health
knowledge as well as awareness of services available at UNHS clinics and increased utilization
of UNHS facilities. This may further support community acceptance of the Patient Centered
Medical Home Model as women may be more inclined to receive all healthcare at their local
clinic. Utilization of local medical students as health educators for the sessions may ensure
consistency, reduce financial burden, and increase overall community resource capacity.

**References:**

CDC. "Centers for Disease Control and Prevention Mortality Data." 30 July 2014. *Centers for Disease


*Tennessee Department of Public Health.* July 2014.


Appendix:

A1. Women’s Health Questionnaire

Women’s Health Programs Questionnaire:

1. What is your age range? (Please circle one)
   a. 14-19
   b. 20-30
   c. 31-40
   d. 41-45
   e. 46+

2. What is the reason for today's visit? (Please circle all that apply)

<table>
<thead>
<tr>
<th>Illness</th>
<th>Annual Exam/Pap Smear</th>
<th>Baby/Child Check-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exam (Job or School)</td>
<td>Pregnancy Test</td>
<td>Diabetes Care</td>
</tr>
<tr>
<td>Follow-Up Visit</td>
<td>Prenatal/Pregnancy Check-Up</td>
<td>High Blood Pressure Care</td>
</tr>
<tr>
<td>Prescription Refill</td>
<td>Birth Control</td>
<td>Asthma/Respiratory Care</td>
</tr>
<tr>
<td>STD test</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

3. How long has it been since your last Annual exam/ Pap smear? (Please circle one)
   0-6 Months  1 Year  2-3 Years  More than 3 Years
4. Are you now, or have you ever been pregnant? (Please circle one, If NO skip to Question 12)
   Yes  No  I Don’t Know

5. During your current or last pregnancy, did you go to the Doctor for prenatal care? (Please circle one)
   Yes  No  I Don’t Know

6. How often do you see the doctor for prenatal care while pregnant? (Please circle one)
   1 or 2 times before delivery  Every 2-3 months  Once or more every month

7. While pregnant, were you offered any pregnancy related educational materials or classes? (Please circle one)
   Yes  No  I Don’t Know

8. Have you ever heard about the Strong Start program?
   Yes  No

9. If Yes, where did you hear about the Strong Start program? (Please check all that apply)
   During my last Doctor’s appointment______ Friend/Family Member_______ Internet_______
   WIC office______ Case Worker______ Other_______________________________________

10. What information do you think may be helpful before, during, and after pregnancy? (Please circle all the apply)

<table>
<thead>
<tr>
<th>Understanding Health Insurance</th>
<th>What to expect during pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding Birth control options</td>
<td>What Prenatal care is and why it is important during pregnancy</td>
</tr>
<tr>
<td>Preventing STD’s</td>
<td>Preventing Pre-term delivery and low birth weight babies</td>
</tr>
<tr>
<td>Talking to your partner about condom use</td>
<td>What community resources are available to help pregnant or parenting moms</td>
</tr>
</tbody>
</table>

11. If offered, would you participate in free monthly health classes or educational workshops held at your local clinic or community center about women’s health issues?
   Not Interested  Somewhat Interested  Interested  Very Interested

12. While pregnant, would you like to participate in free prenatal classes held at your local clinic or community center?
13. What health topics would you like to see presented during the free health classes or educational workshops? (Please Circle all that apply)

<table>
<thead>
<tr>
<th>Not Interested</th>
<th>Somewhat Interested</th>
<th>Interested</th>
<th>Very Interested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Care and Healthy Pregnancy</td>
<td>Women’s Heart Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Babies and Kids</td>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer and Breast Health</td>
<td>Stress Reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy Prevention/Birth Control</td>
<td>Weight Control-Exercise and Nutrition</td>
<td></td>
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</tr>
</tbody>
</table>

14. Are there any other topics or Resources you may be interested in learning more about?


Thank you for your time!
A2. Women’s Health Services Flyer

Women’s Health at UNHS Family Clinics

Prenatal Care

Annual Exams and Screenings

Mental Health

Pre-Teen/Teen Health

Accessing Health Insurance

Birth Control and STD testing

For appointments or more info:
P: 615-620-8647
Same day visits are welcome.

www.unitedneighborhood.org
A3. Women’s Health Education Handout Sample

Pre-Conception Counseling

If you are female, age 14-45, and sexually active, or thinking about becoming sexually active, Pre-Conception (or before pregnancy) counseling is a Must! This is a great time to talk to your provider about birth control, STD testing, or planning a healthy pregnancy!

- Body Mass Index (BMI)
- Blood Pressure
- Medical History
- Abdominal and Pelvic Exams
- Smoking/Alcohol Cessation
- Domestic Violence Screening
- Depression Screening
- STD Testing

Safe Sex is the Best Sex! Meet with your provider, alone or with your partner, to ensure that you are taking all of the necessary steps to avoid an unplanned pregnancy or exposure to sexually transmitted diseases (STDs).

Did You Know?
Birth Control Pills aren’t just for preventing pregnancy! The pill has proved effective for controlling acne, reducing menstrual cramps and bleeding associated with fibroids, regulating irregular cycles, and even helping to manage endometriosis and migraines!

Find out which Birth Control option works best for you!

- Condoms
- Daily Pills
- Weekly Patch
- Monthly Ring
- 3 Month Shot
- 3 Year Implant
- 5-10 Year IUD
- Contraception

Know Your Status!

Get tested! Knowing your status is the best way to protect yourself AND your partner! All UNHS Family clinics offer pregnancy and STD testing on a sliding-fee scale.

- Healthy Mom equals Healthy Baby!
- Talk to your Doctor about: family medical history, medications, cigarette, alcohol or drug use to avoid potential complications.
- Make sure any medical conditions like diabetes, hypertension, seizures, disorders, STD’s, etc. are treated and under control.
- Start taking 400mcg Folic Acid daily before AND during pregnancy to reduce risk of major birth defects of the baby’s brain and spinal cord.

Did You Know?
50% of sexually active young people will get an STD by age 25... Most won’t know they have it.

Did You Know?
Some Birth Control Options are now FREE under the Affordable Care Act!