

Obstetrical Services and Provider-Patient Communication

A qualitative analysis of the communication between providers and patients at Matthew Walker Comprehensive Health Center (MWCHC)

By Vanessa J. Louis

DO Candidate 2016, Philadelphia College of Osteopathic Medicine- Georgia Campus
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Introduction:

I began this project with my own personal interest in the obstetrical and gynecological services of women in underserved areas. Upon arriving to Nashville I discovered that this is an area that is high in infant mortality rate and low birth rates. This made me think of the type of provider-patient communication within community health centers and what could be done to facilitate the pre-natal education available to expectant mothers.

Background:

In 2004, nine of every 1,000 babies born alive in Tennessee died before their first birthday, a rate higher than every other state in the nation except Louisiana and Mississippi (Offices of Research and Education Accountability, 2006). This is particularly an issue in the poorer, minority communities. As with other fields of medicine, obstetrical outcomes differ by maternal race/ethnicity (Bryant, Worjloh, Caughey, & Washington, 2010). Black infants are more likely to be delivered preterm, be born with a lower birth weight and a lower percentage of black women receive adequate prenatal care (Offices of Research and Education Accountability, 2006). These pregnancy outcomes account for most of all neonatal mortality (Sengpiel et al., 2013).

Pregnancy presents an opportune time to engage women in efforts to improve healthy behaviors because of frequent prenatal visits and women may be more motivated to make changes for the sake of their baby (Stotland, Tsoh, & Gerbert, 2012). Maternal behaviors that are related to poor birth outcomes include tobacco use, alcohol use, and failure to consume adequate folic acid through multivitamins or diet. Other conditions that are also associated with poor pregnancy outcomes include unintended pregnancies, experiencing physical abuse, and experiencing high levels of stress (D'Angelo et al., 2007). Providers have a critical role in effectively communicating the importance of pre-natal wellness and referring patients to a health care provider who can meet their needs beyond fetal-care.

Expectant mothers that are patients at community health centers are often reluctant to seek prenatal care earlier in their pregnancy. Care ideally begins before conception and includes preventive care, counseling, and screening for risks to maternal and fetal health (Kirkham, Harris, & Grzybowski, 2005). The contributors to late entry into prenatal care include concerns such as lack of education and insurance coverage, ambivalence about pregnancy and negative perceptions of health care providers and staff (Washington, 2011). Many of these women are not eligible for Medicaid before pregnancy but become so by various income eligibility standards set in pregnancy; however, the application process for pregnancy-related coverage may still present a barrier to early initiation of care (Washington, 2011). Furthermore, women who fail to present for prenatal care are more likely to be non-White (Bryant et al., 2010). It is extremely important to make this patient demographic aware of what they need to do to have a healthy pregnancy, but how should providers communicate prenatal care in these communities?

According to the American Congress of Obstetricians and Gynecologists (ACOG), all prenatal patients should receive counseling about weight gain, diet, and exercise, which are

important factors in both pregnancy outcome and the long-term health of mother and child (Stotland et al., 2012). The idea of preconceptive care is important because it aims to promote the health of women reproductive age before conception and consists of the identification of those conditions that could affect a future pregnancy or fetus and that may be amenable to intervention, thereby improving pregnancy-related outcomes (Johnson et al., 2006; Morgan, Hawks, Zinberg, & Schulkin, 2006).

Observational studies of the clinical interaction from the patient and clinician perspective offer insight into the importance of interpersonal dynamics in quality of care. Clinical interaction research focuses on qualities of communication, qualities of the relationship, or personal characteristics, such as gender and race, that influence interactions (Henderson, Raine, Schalet, Blum, & Harper, 2012). Given the perinatal health disparities in the Nashville community, this study aims to shed light on the provider-patient communication within the Matthew Walker Comprehensive Health Center regarding preconceptive and prenatal care.

Methods:

Interviews

Interviews were conducted face to face at Matthew Walker Comprehensive Health Center (MWCHC) with four providers to find out about provider communication of prenatal healthcare of women. Interviews with clinicians serving the women at the Matthew Walker facility lasted approximately 20 minutes. The providers include obstetrician-gynecologists and nurse practitioners. These questions were intended to allow the providers to answer questions about their patient demographics and specifically about their attitudes towards and experiences communication with expectant mothers (Appendix: Table 1).

Compiling resources

In efforts to create a manual to address the needs of expectant mothers and serve as a reference guide to providers, I first had to look at their current system. I used the electronic medical records screens as a foundation. The screens had the patient's with their medical summary, social history, labs, and education they have received during their pregnancy. The manual was designed to fit the labs and services that MWCHC could provide and the demographic that the providers there specifically serve.

Results:

Providers

The providers in this study discussed features of their patient counseling experiences. There were 4 providers interviewed, two at the Nashville location and 2 at the Smyrna location. Two of the providers were males, two were females, three were physicians and one was a nurse practitioner.

The Typical Patient /Patient demographics

Describe your typical patient.

The providers were asked to describe their patient demographic to identify characteristics about the patients they saw. All providers defined a diverse mixture of races obviously coming from low socioeconomical and educational backgrounds. Most of the expectant mothers were single. Specifically, the African-American population was described as young, unmarried, with multiple children fathered by more than one man. The Hispanic population was described as young and although they may have been unmarried, they typically were less likely to have multiple children

fathered by different partners. Figure 1 shows the patient demographic of all patients at MWCHC in a 2008 annual report.

Essential information

*What is essential information that you (the provider) must communicate to expectant mothers?
What important information do providers need to know about the expectant mother?*

This question was intended to allow the provider to comment on the most important information they give their patients and to identify how information derived from the patient influences the care that they provide. All of the providers stated that they need their patients to know to drink more water and to be sure to take their prenatal vitamins. Moreover, a healthy diet and oral health were also mentioned as important. One provider added that it was crucial for mothers to know the telltale signs of miscarriage or pre-term delivery. Additionally, all providers felt that they needed to know information from their patients as well. Past medical history and past pregnancy history, and fetal movement were the mentioned as the most important things they need to know. As stated by one provider, the patient's access to care, home life and general feeling was important as well.

Effective Communication

How must providers communicate information?

This question was intended to allow the provider to describe their best method of educating their patients and getting them to make the changes necessary for a healthy pregnancy. All of the providers generally felt that they needed to have an open and honest dialogue with their patients. They needed to make sure that their patients understood the importance of diagnostic tests and keeping appointments. They also needed to know information on past medical history and past pregnancies. One provider made a note to say that the patients in this community were

“notoriously non-compliant” and expressed the need for social workers. Another provider stated, “Educational seminars are needed to reinforce the point of healthy eating and behaviors for a healthy baby, however mothers in this community need an incentive to come.”

Patients that cause the most concern

What patients make you (the provider) worried about poor outcomes such as low birth weight, pre-term delivery, and infant mortality? What are lab values typically raise concern?

This question was intended to allow the provider to identify their patients whose lifestyles pose the biggest threats to health outcomes. Adverse social behaviors and eating habits were the most contributing factors related to poor birth outcomes such as low birth weight, pre-term delivery, and infant mortality. A provider’s who said, “There is an increasing number of STDs and marijuana use in the younger population”, corroborated this. Abnormal lab values with a patient’s urinalysis and glucose tolerance test, are among the lab values that raise concern. In addition, younger patients and patients who have previously lost a fetus are among those that warrant caution.

Agreeance

All of the providers within the MWCHC facility has the same concerns about their patients. They displayed a distinct passion to serve this community and understood that there were issues with patient compliance and access to medical care.

Resources

There was a need for a physical document with information and community resources at hand for providers and administration to use as reference. Initially, a needs assessment was performed that evaluated the system MWCHC currently used, and from there, a physical manual was made. Providers use the EMR software to document lab values, diagnostic tests and

education topics they have discussed throughout a woman's pregnancy. After discovering a resource book on prenatal standard of care from the American Academy of Pediatrics and American Congress of Obstetrics and Gynecology (AAP/ACOG, 2007), a manual was adapted to fit MWCHC's needs. A meeting was also conducted with the Medical Director and staff of the OB clinic so that the details were specific to MWCHC. Collectively, all of these procedures ensure that the manual achieves MWCHC's goal of comprehensive women's healthcare by having resources in one place for physicians to use while they are seeing patients (**Appendix: Figure 2**).

Manual Contents

This manual was designed to serve as an efficient resource of information specific to MWCHC providing comprehensive care to women from preconception to post-partum care (**Appendix: Figure 3**). A reference chart was also created to briefly outline procedures that follow a positive or negative pregnancy test (**Appendix: Figure 4**).

Preconception health details the appropriate procedures when a pregnancy is desired or not. If a pregnancy is desired, appointments are arranged in dental, mental and nutritional health departments, in addition to routine physical exam and blood work. This reinforces the idea of optimal health prior to conception increasing positive fetal outcomes. If a pregnancy is not desired, contraceptive methods are discussed and the best option will be chosen the suits the woman's lifestyle. This is a step in the right direction to reducing unintended pregnancies in the Nashville communities.

For pre-natal health, the appropriate labs and screening tests are listed at their appropriate time throughout the various trimesters. In addition, routine mental and dental health evaluations are listed. There are also specific discussion or education topics that the physician should be

discussing with their patient at the time. These topics include breastfeeding, delivery, signs of labor, and recommended books to read.

For post-partum health, the six weeks following delivery, it covers pelvic exam, mental health exam, checking caesarian section sutures, and discussing contraceptives. There is also a section on community resources that are available allow MWCHC to acknowledge community outreach programs that can provide assistance to their patients.

Discussion

When poor pregnancy outcomes occur, they usually have been set in motion long before the first prenatal visit (Morgan et al., 2006). Women who experience an unintended pregnancy are more likely than those with an intended pregnancy to have poor maternal nutrition, to use alcohol during pregnancy, and to have adverse maternal and infant outcomes (D'Angelo et al., 2007). Fortunately, many of the factors contributing to less than ideal birth outcomes can be managed and brought under control through preconceptive care. This preventive measure serves to educate the patient, particularly women who are pregnant for the first time, on what is necessary for a healthy pregnancy. While other areas in medicine have numerous available measures, the single measure that reflects quality of obstetrical care is the proportion of women who receive prenatal care in the first trimester (Washington, 2011).

When pregnancy is confirmed, prenatal care plans, including the choice of caregiver, should be discussed (Kirkham et al., 2005). Women's interactions with health care providers present important opportunities to educate, offer resources, and counsel patients to change risk behaviors (Henderson et al., 2012). Providers should also assess risks to pregnancies based on age, maternal and paternal medical history, obstetric history, and family history (Jack et al., 2008).

It is then the provider's responsibility to ensure that the patient is informed of necessary information, both benefits and risks. It has been suggested that successful interventions targeting these behaviors prior to pregnancy are associated with improved health of the woman and her infant (D'Angelo et al., 2007). As of yet, there have not been any clear quality standards for the provision of preconception, prenatal, intrapartum and postpartum care and thus, the creation of such guidelines will provide better benchmarks for quality and equality of obstetrical care among all (Bryant et al., 2010).

Based on the interviews conducted, it was evident that the providers shared the same views on patient needs. They all shared the same demographic of patients, which made it highly likely that they would face the same challenges with patients. All of the providers stated that a majority of their patients were non-compliant. However, one provider elaborated on this concept and stated, "Sometimes their non-compliance, failure to show up for appointments, failure to take pre-natal vitamins, is due to their access to care being hindered by finances and transportation". This is an interesting fact to note, as it is important to recall that the community MWCHC serves is high in minorities, immigrants, and those of disadvantaged socioeconomical status. These disparities ultimately contribute to disparate rates of infant and maternal mortality, and thereby reflect the overall health status of the communities in which women and their families live. Health care itself plays a clear role in health disparities, and health care policy and quality improvement efforts should aim to broaden access and increase the quality of obstetrical care available to all women (Bryant et al., 2010).

The manual that was created for the MWCHC to use was designed to aid the procedure of standardizing the care amongst all who serve expectant mothers. It covers important labs and educational information that women should know from pre-conception through post-partum. For

example, information about physiologic changes that occur during pregnancy and preparation for the birthing process are key themes around which to discuss care issues and choices such as breastfeeding (Kirkham et al., 2005). Post-partum care visits provide important opportunities to assess the physical and psychosocial well being of the mother, counsel her on infant care and family planning, and detect and give appropriate referrals for preexisting or developing chronic conditions such as diabetes, hypertension, or obesity (“Postpartum care visits--11 states and New York City, 2004.” 2007). The health center is also taking the initiative in women’s pre-natal care by administering prenatal vitamins to all women who have a positive pregnancy test.

This manual also aids this department in administering comprehensive care by also incorporating mental and dental health initiatives within the standard of care. American College of Obstetricians and Gynecologists (ACOG) recommends psychosocial screening of pregnant women at least once per trimester, yet screening is uncommonly done (Connelly, Baker-Ericzen, Hazen, Landsverk, & Horwitz, 2010). Moreover, this manual will serve as a foundation to the clinical services MWCHC can provide as well as serve a template for other departments to follow. A digital copy will be kept so that the administration can modify and update this document as the facility grows.

In conclusion, the interviews can serve as a pilot study for future projects. Future projects can interview more providers to get a better perspective of the state of maternal health in Nashville as a whole. Moreover, this study can also be expanded to interview expectant mothers to see how they rate their communication experience with the providers at MWCHC and other healthcare facilities.

Appendix

Table 1. Questions that the providers were asked.

Questions
1. Describe your typical patient.
2. What is essential information that you (the provider) must communicate to expectant mothers?
3. How must providers communicate information?
4. Are patients usually compliant?
5. What important information do providers need to know about the expectant mother?
6. What patients make you (the provider) worried about poor outcomes such as low birth weight, pre-term delivery, and infant mortality?
7. What lab values typically raise concern?

Figure 1. Matthew Walker Comprehensive Health Center serves a diverse population of patients that are underserved and underinsured.

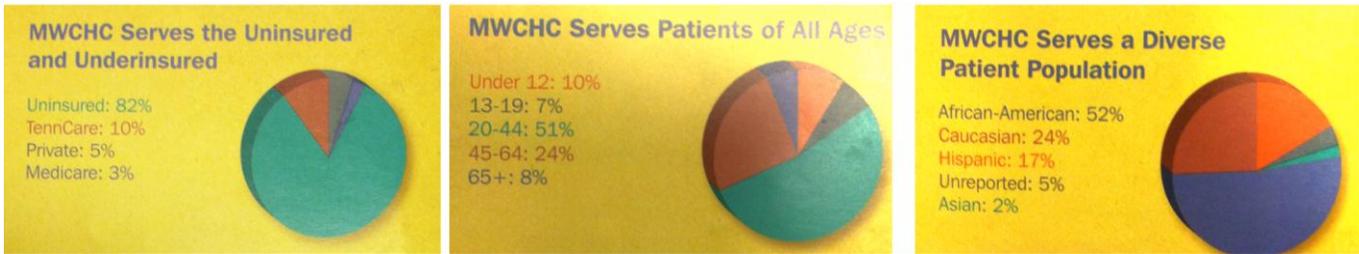


Figure 2. The cover of the manual for the OB department at Matthew Walker Comprehensive Health Center.

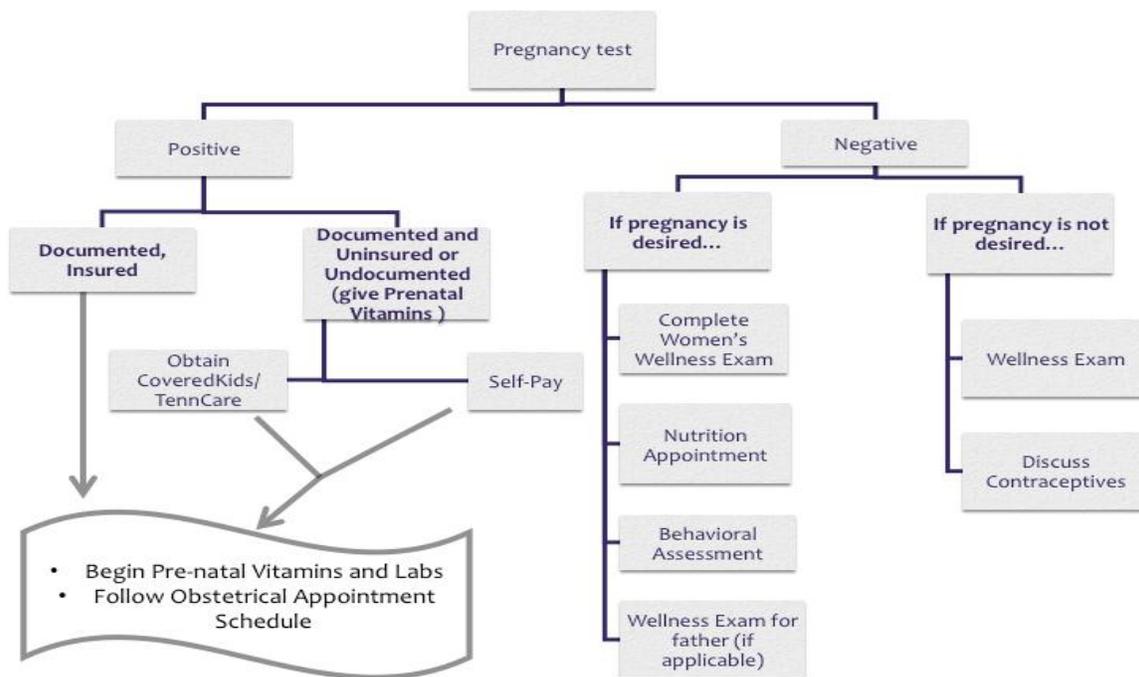
Obstetrical Services
at Matthew Walker Comprehensive Health Center
Standard of Care Manual



Figure 3. The table of contents of the manual for the OB department at Matthew Walker Comprehensive Health Center.

Table of Contents	
MISSION	1
PRECONCEPTUAL VISIT	2
MATERNAL HEALTH	3
VISIT SCHEDULE	4
INITIAL VISIT	5
SECOND TRIMESTER VISIT	8
THIRD TRIMESTER VISIT	9
POST-PARTUM VISIT	10
COMMUNITY RESOURCES	11
RESOURCES	12

Figure 4. Quick reference chart for when a pregnancy test is administered.



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