EARLY ENTRY INTO PRENATAL CARE

Overcoming barriers and improving access to care

RESOURCE GUIDE
ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

The March of Dimes mission of improving the health of babies by preventing birth defects, premature birth and infant mortality thrives strongly on the premise of women getting into early prenatal care. Prenatal care is important for the health of both the mother and the baby.

Unfortunately, too many women do not seek care when they learn they are pregnant that may result in an increase in undetected high risk pregnancies, cesarean sections, and prematurity. Mothers who do not receive any prenatal care are more likely to deliver a low birth weight baby than mothers who do not receive care, and the infant mortality rate is higher. Prenatal care - beginning early and continuing throughout pregnancy - is one of the most effective interventions to reducing prematurity and improving birth outcomes.

Early prenatal care support healthy babies, healthy women, and healthy births. During prenatal care, health care providers monitor the health of the mother and baby and identify and treat health conditions and issues that could impact the pregnancy. It is also an important time for providers to educate mothers on a variety of health issues related to pregnancy, such as smoking, alcohol use, exercise, nutrition, preparing for childbirth, infant care and breastfeeding. When we look at the impact of these risk factors, the earlier the intervention, the better.

Recognizing the importance of early prenatal care, this toolkit, based on the Legacy Southwest Clinic example, was created to provide physician offices and clinics tools and resources to improve early prenatal care and retention. Throughout the toolkit, boxes marked “Case Studies” further highlight Legacy’s programs and strategies developed and implemented in the community. While every community is different and has unique challenges, opportunities and a collection of resources, we hope this guide will serve as valuable sources of ideas and innovations to improving early prenatal care rates.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of the guide</td>
<td>5</td>
</tr>
<tr>
<td>Intended audience</td>
<td>5</td>
</tr>
<tr>
<td>Overview of sections</td>
<td>6</td>
</tr>
<tr>
<td>Develop QI infrastructure</td>
<td>7</td>
</tr>
<tr>
<td>Establish quality improvement team</td>
<td>7</td>
</tr>
<tr>
<td>Make it your mission</td>
<td>10</td>
</tr>
<tr>
<td>Establish communication channels</td>
<td>11</td>
</tr>
<tr>
<td>Understand the need</td>
<td>13</td>
</tr>
<tr>
<td>Know your numbers</td>
<td>13</td>
</tr>
<tr>
<td>Know the barriers to care</td>
<td>16</td>
</tr>
<tr>
<td>Know your community partners</td>
<td>19</td>
</tr>
<tr>
<td>Increase access to care</td>
<td>21</td>
</tr>
<tr>
<td>Market your services</td>
<td>22</td>
</tr>
<tr>
<td>Provide free pregnancy tests</td>
<td>24</td>
</tr>
<tr>
<td>Establish patient navigator position</td>
<td>24</td>
</tr>
<tr>
<td>Utilize presumptive eligibility</td>
<td>26</td>
</tr>
<tr>
<td>Measure progress</td>
<td>27</td>
</tr>
<tr>
<td>Case studies</td>
<td>29</td>
</tr>
<tr>
<td>Conclusion</td>
<td>39</td>
</tr>
<tr>
<td>Appendices</td>
<td>40</td>
</tr>
</tbody>
</table>
PURPOSE OF THE GUIDE

Early and adequate prenatal care is important to the health of both mother and baby. Early prenatal care allows for early and timely treatment that can help manage many health problems and/or prevent others. Early entry into prenatal care is defined as entry into care within thirteen weeks of a mother’s last menstrual period. Delayed entry into prenatal care has been associated with adverse outcomes such as low birth weight, preterm births, conditions associated with prematurity, and mortality. When women attend care early in their pregnancies, health care providers can help identify the medical, nutritional, educational, and social interventions needed to reduce the risk of adverse pregnancy outcomes.

The March of Dimes is committed to addressing early entry into prenatal care to reduce negative health outcomes for mothers and babies. This toolkit is designed to give those on the front lines of maternal and child healthcare the resources needed to increase access to early prenatal care in communities across the U.S. Specifically, this toolkit provides users with the resources to 1) establish quality improvement initiatives to address early entry into prenatal care in their clinics, 2) understand the needs in their community related to prenatal care, 3) increase access to early prenatal care, and 4) measure progress.

INTENDED AUDIENCE

This toolkit is written for health care providers, hospitals, social workers, home visitors, grassroots organizations, or institutions providing medical and social services to pregnant women. While we use the term “clinic” throughout this document, we understand that a diverse number of healthcare institutions can and will benefit from the strategies provided. We know that every community is different, and every community has unique challenges, opportunities, and resources to improve prenatal care outcomes. We hope this guide will serve as a valuable source of ideas and strategies to increase prenatal care in your community.
OVERVIEW OF SECTIONS

This resource guide is divided into five sections: 1) Develop Quality Improvement Infrastructure; 2) Understand the Need; 3) Increase Access to Care; 4) Measure Progress; and 5) Case Studies.

Sections 1-4 describe tasks for developing, launching, and evaluating your quality improvement initiative to increase early entry into prenatal care. We include lists of resources for further reading and links to tools to help you along the way. Figure 1 illustrates the relationships between the tasks.

Develop quality improvement infrastructure. We provide resources to help you establish a quality improvement team, identify goals and objectives, and establish communication channels.

Understand the need. We include resources to help you identify your baseline early entry into prenatal care rates, understand the barriers to care for your patients, and engage stakeholders and partners.

Increase access to care. We describe sample strategies to implement that may help increase early entry to care such as marketing your services, providing free pregnancy tests, engaging a patient navigator, and utilizing presumptive eligibility.

Measure progress. We provide resources to help you evaluate your quality improvement efforts and sustain your successes.

Section 5 includes clinic case studies of three quality improvement teams in Texas. These case studies provide brief descriptions of the strategies the teams used to assess their early entry into prenatal care rates, improve systems, and create positive change for their patients.
1 DEVELOP QI INFRASTRUCTURE

There are three key steps to launching your quality improvement initiative (QI) to increase early access to prenatal care at your clinic:

1. Establish a quality improvement team
2. Make it your mission
3. Establish communication channels

In this section, we provide resources to help you build organizational infrastructure and put together a team that will spearhead efforts to create positive change in your clinic. For each step, we provide helpful links to online resources, templates, educational modules, and readings so that you feel confident launching your quality improvement initiative to increase early access to prenatal care.

1.1 ESTABLISH QUALITY IMPROVEMENT TEAM

Quality improvement (QI) teams or committees are groups of individuals within a practice charged with carrying out improvement efforts—in this case increasing early entry into prenatal care. Many times, QI teams are led by a clinic “champions,” an individual or team of individuals committed to improving processes and procedures related to the QI initiative. Champions may lead efforts to gather and evaluate data, seek out best practices, and engage individuals involved in all aspects of the initiative. It is important to have all perspectives heard during a QI initiative — providers, staff, community leaders, and patients. The role of the QI champion is to ensure that perspectives are heard, the team functions effectively, and the team fulfills its quality improvement goals.

To increase early entry into prenatal care, QI teams should communicate early in the process to the organization’s leadership and/or governing board about the overarching goals of the initiative and expected outcomes. Once established, the QI team should meet regularly to review performance data, identify areas in need of improvement, and evaluate improvement efforts. For these activities, there are a variety of QI approaches and tools that can be used including: the Model for Improvement (MFI), Plan Do Study Act (PDSA) cycles, workflow mapping, assessments, audit and feedback, benchmarking, and best practices research.
RESOURCES FOR IMPLEMENTATION

US DHHS Agency for Healthcare Research and Quality
The US Department of Health and Human Services (DHHS) Agency for Healthcare Research and Quality (AHRQ) developed a Practice Facilitation guide that describes how clinic leaders or champions can use practice facilitation methods to improve practice. Clinic champions may find the Creating Quality Improvement Teams and QI Plans module particularly helpful.

US DHHS Health Resources and Services Administration
The DHHS Health Resources and Services Administration (HRSA) website includes a health center quality improvement section with resources about strategic partnerships, clinic and financial performance measures, and ongoing clinic quality improvement initiatives they support.

HSRA Quality Improvement Module
Published in 2011, HRSA released a series of modules describing quality improvement initiatives to improve health. Their Quality Improvement module includes the following informative sections: 1) quality improvement and its importance; 2) establishing an organizational foundation for quality improvement; 3) the journey towards improvement; and 4) keeping the momentum going.

HSRA Prenatal — First Trimester Care Access Module
Another informative resource from HRSA is the First Trimester Care Access module. Highlighting many of the points in this resource guide, the module includes the following sections: 1) performance measurement; 2) characteristics of success; 3) implementation; 4) improvement strategies; 5) and holding gains and spreading improvements.

The Community Tool Box
The Community Tool Box, developed at the University of Kansas Center for Community Health and Development, is a comprehensive website to assist researchers, nonprofit organizations, and healthcare organizations build healthy communities. The website aims to help change agents learn new skills, take action, and connect to one another. QI Champions may find the Group Facilitation and Problem Solving module helpful in facilitating QI teams.
The Institute for Healthcare Improvement

The Institute for Healthcare Improvement (IHI) website links clinic champions and quality improvement teams to an array of QI topics including maternal and child health and primary care access. IHI also offers in-person training, virtual training, and online quality improvement courses.

March of Dimes

The March of Dimes Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age Toolkit offers a helpful checklist in the mobilization of QI teams. We have developed an adapted checklist (Appendix A) for early entry into prenatal care quality improvement initiatives.

Self Assessment Tool

We developed a brief Self Assessment Tool (Appendix B) to help you get started in your EEPNC quality improvement initiative. Use this tool to brainstorm clinic activities, patients’ needs, and quality improvement team members as you build a system to improve early entry into prenatal care.

Quality Improvement Brainstorm and Planning Tool

We developed the Quality Improvement Brainstorm and Planning Tool (Appendix C) for quality improvement teams to use as they read through this resource guide and think about strategies to increase access to care. Utilize this tool to assess your clinic’s current practices and to brainstorm ideas as you establish quality improvement infrastructure, understand the need, and increase access to care.
1.2 MAKE IT YOUR MISSION

Making access to prenatal care a priority is important for obtaining organizational buy-in, for creating positive change in your organization, and for impacting your community. Quality improvement teams can “make it their mission” by creating clear goals and by developing SMART (Specific, Measurable, Achievable, Realistic, Time-bound) objectives for obtaining those goals. By focusing on specific and clear goals, teams can be effective in aligning resources both internally and externally, fostering an environment to accomplish set objectives, and ultimately improve patient outcomes.

While this resource guide is not designed to assist organizations with building operative mission statements, we do encourage clinics to examine their current mission statements and consider developing short-term mission statements to direct their quality improvement initiatives. Mission statements are essential in helping an organization focus on what really matters – to both the employees and to the community it serves. Your mission statement should be a source of motivation and direction for your clinic’s employees and quality improvement team by reaffirming their commitment to the clinic’s purpose and to providing the best possible care for your patients.

RESOURCES FOR IMPLEMENTATION

The Community Tool Box

The Community Tool Box includes of resources to brainstorm goals, create objectives, and keep quality improvement teams on task. Clinic champions and quality improvement teams may find the following chapters useful while “making it your mission” to improve early entry into prenatal care: 1) Vision, Mission, Objectives, Strategies, and Action Plans; 2) Developing Vision and Mission Statements; 3) Creating Objectives; and 4) Developing an Action Plan.

SMART Objectives Template

We have created a SMART Objectives template (Appendix D) for your quality improvement teams to brainstorm overall goals and specific SMART objectives to increase entry into prenatal care in your clinic.
1.3 ESTABLISH COMMUNICATION CHANNELS

Clear communication channels and plans are essential to efficient and transparent quality improvement initiatives. Ensuring team members are aware of processes, updates on goals, and bumps in the road along the way is essential to progress and to creating positive outcomes for your patients. Communication channels and clear communication plans should be developed for both internal and external communications. For example, the quality improvement team will need to regularly communicate with clinic leadership. Similarly, the team will need to communicate goals and plans with community stakeholders and partners. Other outside communication may include the following: news stories to highlight clinic services; posters, brochures, and fliers; outreach presentations to community organizations; or special events or open houses. Box 1.3 includes questions to consider as you build your communication plans.

Box 1.3 Communication plan brainstorming questions*

What is our purpose?
- What do you want to communicate with the community? With clinic leadership? With staff? With stakeholders?

What is the message?
- What are the main ideas? What details do we include? Who needs to know what in order to stay up to date on progress?

How often should we communicate?
- Should we meet with leadership monthly? Quarterly? What is the timeline? How often should we meet with our partners?

How will we disseminate our message?
- Are we developing a comprehensive report? Should we develop a press release? Is this a memo to staff?

* Adapted from The Community Toolbox.
2 UNDERSTAND THE NEED

After establishing your quality improvement team, it is time to examine your baseline and understand the need in your community. There are three key steps to understanding the need for increased access to prenatal care in your community and patient population:

1. **Know your numbers**
2. **Know the barriers to care**
3. **Know your community partners**

In this section, we discuss the importance of gathering baseline data and of understanding potential barriers your patients may experience in accessing care. We also highlight the importance of partnerships and resources as you begin your quality improvement initiative. For each step, we provide resources, examples, and sample documents to capture your data.

2.1 KNOW YOUR NUMBERS

It is important to know what EEPNC looks like at your clinic or organization before you can determine what changes may be needed to infrastructure, systems, or policies. Chart reviews of a select percentage of your patient pool can help you determine the proportion of patients accessing care during their first trimester and help you gather baseline information on organizational activities carried out prior to implementing a quality improvement initiative. Assessing and comparing clinic rates of early prenatal care to national goals and benchmarks can further help you develop a targeted approach to addressing early prenatal care at your clinic and effectively measure outcomes when evaluating your impact. Key questions to answer as you begin your initiative include the following:

- What proportion of pregnant women received prenatal care beginning in their first trimester at my clinic/hospital in the previous three months?
- Does the proportion of pregnant women receiving prenatal care beginning in their first trimester at my clinic/hospital meet goals and objectives set forth by local, state, or national agencies?

* Note the time interval your clinic chooses to measure may be different.
RESOURCES FOR IMPLEMENTATION

The Community Tool Box

The Community Tool Box, developed at the University of Kansas Center for Community Health and Development, is a comprehensive website to assist researchers, nonprofit organizations, and healthcare organizations build healthy communities. The website aims to help change agents learn new skills, take action, and connect to one another.

While the whole Tool Box provides valuable information, the Communications chapter may be most helpful as you establish communication channels. The chapter includes 19 sections including a section devoted to developing a plan for communication.

Additional Tool Kit sections may be helpful as you begin to engage with community stakeholders, market your services to increase access, or share your successes with the media.

These include the following:

- Developing fact sheets on local issues
- Arranging news and feature stories
- Preparing guest columns and editorials
- Preparing public services announcements
- Preparing press releases
- Using paid advertising
- Creating posters and fliers
- Creating brochures
National benchmarks

Healthy People 2020 states two specific objectives related to early prenatal care that may be helpful as you assess your numbers.

<table>
<thead>
<tr>
<th>Healthy People 2020 Objective</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>MICH-10.1: Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester.</td>
<td>77.9%</td>
</tr>
<tr>
<td>MICH-10.2: Increase the proportion of pregnant women who receive early and adequate prenatal care.</td>
<td>77.6%</td>
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</tbody>
</table>

For more information on Healthy People 2020 objectives related to Maternal, Infant, and Child Health please visit [www.healthypeople.gov](http://www.healthypeople.gov). Specific information on Healthy People data, measurements, and methodologies are available for each objective listed [here](http://www.healthypeople.gov).

Baseline questions

Baseline data on clinic factors, patient demographics, prenatal care rates, and patient outcomes give you a starting point and can help you develop your quality improvement goals. Consider the additional baseline questions in Box 2.1 as you begin your quality improvement initiative.

Box. 2.1 Baseline questions - EEPNC Quality Improvement Initiative

Clinic:

- What is the average number of patients served per month?
- What is the average number of prenatal patients served per month?
- What is our current patient to provider ratio?

Patient Demographics:

- Gather the following patient demographic information:
  - Top 3 zip codes where your obstetrical (or general) patient population reside
  - Description of the race/ethnic diversity of your population (i.e., percent African American, Caucasian, Hispanic, or Other)

* Adequacy of prenatal care is measured by the Adequacy of Prenatal Care Utilization Index combining the month that a mother begins prenatal care with the number of prenatal visits. More information can be found on the Healthy People 2020 website at [www.healthypeople.gov](http://www.healthypeople.gov).
EARLY ENTRY INTO PRENATAL CARE RESOURCE GUIDE

- Description of the race/ethnic diversity of your population (i.e., percent African American, Caucasian, Hispanic, or Other)
- Proportion of English proficiency patients served and major languages spoken by your patients (ex. Spanish-speaking only vs. limited English proficiency vs. others)
- Percentages of Medicaid, CHIP prenatal, private insurance and uninsured patients

Prenatal Care:
- What percentage of your obstetric patients in 20XX or in Q1 and Q2 of 20XX entered prenatal care in the:
  - First trimester of their pregnancy?
  - Second trimester?
  - Third trimester?

Patient Outcomes:
- How do we track patient delivery outcomes? Who has access to this data?
- What percentage of prenatal care patients are seen for a six-week postpartum check-up?

RESOURCES FOR IMPLEMENTATION

NCQA Protocol for Timeliness of Prenatal Care
The National Committee for Quality Assurance (NCQA) provides detailed instructions on how to pull patient data to capture baseline data. The NCQA protocol assesses timeliness of prenatal care and postpartum care for mothers.

HSRA UDS Protocol to Identify First Trimester Entry into Prenatal Care
The Health Resources and Services Administration (HRSA) Uniform Data System (UDS) also provides detailed instructions on how to pull data for patient records and capture baseline data. The prenatal care instructions are part of a larger quality improvement data reporting protocol. HRSA UDS also provides table templates. We created an abbreviated data log using the HRSA UDS protocols to help you identify your baseline numbers (Appendix E).
2.2 KNOW THE BARRIERS TO CARE

Improving early prenatal care numbers is challenging since patient barriers to care are often complex. Engaging with your community and speaking with local residents, community leaders, stakeholders, and partners can help you to understand cultural beliefs, social norms, and attitudes that affect how your patients interact with the healthcare system. They can also help identify barriers such as transportation or childcare needs that keep patients from attending care.

Barriers to care can exist at different levels including personal barriers, financial barriers, provider barriers, and system barriers. For example, in Texas, Pregnancy Risk and Monitoring Systems (PRAMS) 2011 data indicated the top three barriers to prenatal care for Texas women as the following:

- Lack of money to pay for care (financial barrier)
- Lack of a Medicaid card (financial barrier)
- Inability to obtain an appointment (system level barrier)

By acknowledging and addressing these barriers, Texas clinics had a significant opportunity for positive impact and change. Examples of Texas clinics addressing these barriers and more are included in the Case Studies.

To identify barriers, you may choose to work directly with patients or with community partners. Focus groups or interviews are helpful techniques to identify barriers to care in your community. Questions may center on when and why patients sought prenatal care, and discussions can help uncover barriers at the different levels. It is important to note that focus groups or interviews may not be feasible or accepted with your patient population. Instead, you may need to speak with staff or providers to identify what they hear directly from patients as barriers.

Community gatekeepers, leaders, and partners are also great resources in helping you develop a deeper understanding of potential barriers. Interviews or meetings with these partners can highlight strengths in your community or areas that need improvement. Section 2.3 expands on the importance of community partnerships and resource sharing.
RESOURCES FOR IMPLEMENTATION

The Community Tool Box

The Community Toolbox includes a comprehensive section on Assessing Community Needs and Resources that may be helpful as you begin to look at barriers to care in your community. This section contains 24 subsections including the following:

- Developing a plan for assessing local needs
- Understanding and describing the community
- Collecting information about community problems
- Analyzing information about community problems
- Conducting interviews
- Conducting focus groups
- Leading a community dialogue
- Involving people most affected by the problem
- Assessing community needs and resources
- Identifying and analyzing stakeholders and their interests

The Tool Box also includes a comprehensive Assessing Community Needs and Resources Toolkit to walk you through the process and the materials online.

Pregnancy Risk Assessment Monitoring System (PRAMS)

The CDC is a great resource for data and materials as you begin your quality improvement initiative. Specifically, the Pregnancy Risk Assessment Monitoring System contains state-specific data on maternal attitudes and experiences before, during, and after pregnancy. The data covers over 80% of all US births. PRAMS data have been used to understand preconception health, patterns of insurance coverage among pregnant women, and disparities. Considering utilizing PRAMS data to inform your quality improvement initiative and join others who have successfully used the resource to improve care for mothers and babies. You can read about success stories here.
American Hospitals Association

The American Hospitals Association has a number of tools to including taskforce findings, webinars, and toolkits to help you identify barriers to care and engage with community members. The following resources may be particularly helpful:

- Engaging patients and communities in the community needs assessment process guide
- Applying research principles to the community needs assessment process guide
- Ensuring access in vulnerable populations—taskforce report and resources

Association for Community Health Improvement

The Association for Community Health Improvement includes a comprehensive Community Health Assessment Toolkit. The toolkit describes nine steps and includes case examples of healthcare organizations partnering with communities to identify and address critical needs. Similar to the process described in this resource guide, the nine steps include the following:

1. Reflect and strategize
2. Identify and engage stakeholders
3. Define the community
4. Collect and analyze data
5. Prioritize community health issues
6. Document and communicate results
7. Plan implementation strategies
8. Implement strategies
9. Evaluate progress

Individual and Environmental Barriers Logic Model

We created an Individual and Environmental Barriers Logic Model (Appendix F) to help you brainstorm barriers to care such as maternal attitudes or beliefs and environmental-level barriers such as transportation or social norms. To learn more about developing logic models of health problems and behaviors see Green and Kreuter’s Health Program Planning: An Educational and Ecological Approach or Planning Health Promotion Programs: An Intervention Mapping Approach by Bartholomew, et al.
2.3 KNOW YOUR COMMUNITY PARTNERS

Knowing your patient population, understanding your community context, assessing resources, and knowing your community partners are critical steps to starting your EEPNC quality improvement initiative. Partners can help you identify potential barriers to care and develop solutions.

When you know your community and engage with partners, you can tailor interventions and programs to the community's norms and culture. Partnerships and collaborative relationships enhance and improve services, and they can connect pregnant women to comprehensive medical and public health services early and throughout their pregnancy. Partnerships with local leaders, stakeholders, organizations, or governmental bodies should be considered community assets. These assets include physical structures or places where community members congregate, community service organizations, or local businesses, to name a few.

Examples of partners may include*:

- Elected officials
- Community planners and development officers
- Chiefs of police
- School superintendents, principals, and teachers
- Directors or staff of health and human service organizations
- Health professionals
- Clergy
- Community activists
- Housing advocates
- Presidents or chairs of civic or service clubs -- Chamber of Commerce, veterans' organizations, Lions, Rotary, etc.
- People without titles, but identified by others as "community leaders"
- Owners or CEO's of large businesses (these may be local or may be large corporations with local branches)

* Source: The Community Toolbox
RESOURCES FOR IMPLEMENTATION

The Community Tool Box

The Community Tool Box includes a number of resources to help you identify and build relationships with your community partners. The following sections may be particularly helpful as you implement your quality improvement initiative to increase early entry into prenatal care:

- Developing multisector collaborations
- Assessing community needs and resources
- Creating and gathering a group to guide your initiative
- Involving key influential in the initiative
- Identifying and analyzing stakeholders and their interests

Making Community Partnerships Work: A Toolkit

The March of Dimes created Making Community Partnerships Work: A Toolkit filled with helpful tools and resources for engaging with your community to bring about positive change. The Toolkit includes the following helpful sections:

1. Assessing readiness to engage in community-based participatory partnerships
2. Approaching and involving community members
3. Formalizing and maintaining a partnership
4. Templates and sample documents to keep your quality improvement initiative moving forward.

American Hospital Association

The American Hospital Association website includes a guide for fostering hospital-community partnerships to build a culture of health. This resource may be helpful as you build and/or strengthen your partnership with other local healthcare institutions.

Community Partner Form

The Community Partner Form (Appendix G) is a template from Making Community Partnerships Work: A Toolkit. Your clinic may have an extensive list of partners already, or you may find that key organizations or individuals are missing from the table as you engage in your quality improvement initiative. The Community Partner Form can help you brainstorm new partnerships in a variety of sectors.
3 INCREASE ACCESS TO CARE

In this section we highlight some strategies you may consider implementing in order to increase access to prenatal care at your clinic. These include:

1. Marketing your services
2. Providing free pregnancy tests
3. Establishing a patient navigator
4. Utilizing presumptive eligibility

We know every clinic is different. Some may already engage in the strategies we’ve listed here, and some may not. For example, some may already offer free pregnancy tests to patients while others may not have the capacity to offer the tests. In the Case Studies, you will read about clinics that adopt these strategies as part of their quality improvement initiative, and you will read about others that already have strategies in place, but they need to strengthen them. Again, every clinic is different. This section is meant to help you brainstorm about the strategies you may be able to implement, or improve upon if you already implement them, so that you can increase early prenatal care in your clinic, and these four strategies are just the tip of the iceberg.

One important question to consider as you read through this section is “How can we make accessing care at our clinic more convenient for patients?” For example, a mother may want to access care early in her pregnancy, but she may feel it is difficult to do so because of clinic hours or lack of insurance. Knowing your patients' barriers can help you identify changes you need to make or systems you can strengthen to make accessing care more convenient.

Consider clinic hours and patient access. Service hours have been cited as a barrier to care, particularly for low-income communities and minority populations. If this is a significant barrier for your patients, can you extend clinic hours? What would need to change in order to open on a Saturday or close late one day a week? Considering this barrier and assessing how you may be able to accommodate patients is key to increasing access and making care more convenient for your patients.
3.1 MARKET YOUR SERVICES

Publicity, marketing materials, and word-of-mouth communication increase your clinic’s visibility, and they increase community awareness of your clinic’s brand, mission, and available services. Clear, community-appropriate, and targeted marketing materials ensure that families have accurate information about your clinic’s services. These materials may be distributed at community health fairs, in local businesses, or via mail campaigns depending on your community. It is important to keep in mind that word-of-mouth may be an important marketing tool in your community. Women with a positive experience at your clinic are more likely to refer friends and relatives to seek care at your clinic.

Culturally appropriate marketing materials are important. Patients need to be able to identify with the women on the materials, and messages should be tailored to your community. For example, consider using images that reflect the race/ethnicities of women at your clinic. You may also consider translating the materials into other languages for patients who have low English proficiency. Pretesting materials is helpful as you develop or tailor your materials. You may choose to hold a focus group with a small number of patients to gain their perspectives on the materials with questions focused on both the aesthetics and content of the materials.

RESOURCES FOR IMPLEMENTATION

The Community Guide

The US Department of Health and Human Services Guide to Community Preventive Services (The Community Guide) is a collection of evidence-based findings based on systematic reviews of interventions and implementation strategies to improve health. The Guide recommends campaigns that include mass media and health-related product distribution to promote behavior change and improve health. The website includes the rationale for their examination of mass media as a tool for communication, the detailed review of their findings, an economic analysis of using mass media, and considerations for implementation.
RESOURCES FOR IMPLEMENTATION

The Community Tool Box

The Community Tool Box includes comprehensive chapters on media advocacy and using social marketing to market and help spread the message about your program, clinic, or services. Particularly relevant sections include the following:

- Working with the media
- Creating news stories
- Using paid advertising
- Conducting a social marketing campaign
- Segmenting the market to reach the target population

Additionally, the Tool Box includes an Implementing Social Marketing Toolkit to help you think through and develop a campaign that markets your services to your community.

Sample focus group guide

We developed a sample focus group guide (Appendix H) for pretesting your materials with your patient population and community members. Use this guide as you develop materials to market your services. Pretesting materials and receiving feedback can ensure your materials are appropriate and relevant to your patient population and community.
3.2 PROVIDE FREE PREGNANCY TESTS

Early pregnancy identification is essential in improving early entry into prenatal care rates, and programs that support early identification are cited as best practices in improving early entry rates. Free pregnancy tests can be an initial point of contact for a patient at your clinic. By engaging with pregnant mothers as soon as there is a confirmed test, your team can ensure all mothers – especially those that are high risk – are effectively taken care of as soon as possible. Patient navigators and trained clinic staff can immediately assist a woman with positive pregnancy test results by enrolling her in Presumptive Eligibility (Section 3.4), scheduling her first prenatal appointment, and responding to any questions she may have.

RESOURCES FOR IMPLEMENTATION

US DHHS Office of Women’s Health

The US Department of Health and Human Services Office of Women’s Health offers a pregnancy test frequently asked questions handout that may be helpful for your patients. The document is available in both English and Spanish.

3.3 ESTABLISH PATIENT NAVIGATOR POSITION

Collaborative care models and systems set up to help patients navigate healthcare systems positively impact patient outcomes. Therefore, Patient Navigators are becoming increasingly important resources in health clinics. A Patient Navigator can be instrumental in ensuring patients access early prenatal care, continue care throughout a pregnancy, and attend postnatal appointments. Navigators are “trained, culturally sensitive health care workers who provide support and guidance” for patients. A Navigator may be a first point of contact at your clinic for a woman who has just found out about a pregnancy, and the navigator can help the new patient move through a potentially unfamiliar healthcare system as she seeks care. First contact with a new patient is often a missed opportunity to “triage” patients. Therefore, trained Patient Navigators may be especially important in ensuring potentially high-risk patients are seen as soon as possible.
A Patient Navigator may help patients in a variety of ways such as following:

- Assisting in enrollment for Medicaid or managed care programs
- Prenatal appointment scheduling
- Translation services
- Referral for additional services

RESOURCES FOR IMPLEMENTATION

Patient Navigator Training Collaborative

The Patient Navigator Training Collaborative provides resources to grow your patient navigation program. The Collaborative’s mission is “to provide national leadership for the development, education, standardization, and sustainability of the growing patient navigation workforce.” Useful resources include a range of courses for patient navigators to gain additional skills and a toolkit on how to evaluate your patient navigation program.

Patient Navigation Toolkit

The Boston Medical Center Patient Navigation Toolkit can help design and implement a comprehensive patient navigation program at your clinic. Developed by the Boston Medical Center and Avon Foundation for Women, the toolkit includes real-world case examples, practical and interactive tools, and resources to help you get started.

The Community Tool Box

The Community Tool Box includes a chapter on hiring and training talented staff. Details covered include developing a job description, advertising, interviewing, and orienting new staff. These tools may be helpful as you develop a new position, expand responsibilities for an existing position, or add additional staff at your clinic.

Patient navigator responsibilities

In the sample patient navigator responsibilities resource (Appendix I) we highlight examples the duties and responsibilities of Navigators specifically established to help women access early prenatal care. You can use these descriptions as guides as you develop the position within your clinic or organization, and tailor the duties as needed for your clinic and community context.
3.4 UTILIZE PRESUMPTIVE ELIGIBILITY

Lack of insurance has repeatedly been shown to be one significant barrier to women accessing prenatal care early. Presumptive eligibility in Medicaid has become an important strategy for improving access to prenatal care for low-income pregnant women. Presumptive eligibility provides temporary Medicaid coverage to pregnant women whose family income does not exceed the state’s Medicaid limit. The intent of presumptive eligibility is to provide the earliest possible access to prenatal care to improve maternal and child health outcomes and reduce the barrier of lack of insurance when accessing care. Clients with presumptive eligibility receive immediate, short-term Medicaid eligibility while their formal Medicaid application is processed. Presumptive eligibility assists established community-based organizations, federally qualified health centers, and other approved qualified entities to meet the needs of pregnant women.

RESOURCES FOR IMPLEMENTATION

Medicaid and CHIP FAQs

The US Department of Health and Human Services developed a Medicaid and CHIP FAQs document on implementing hospital presumptive eligibility programs. Information includes application processing, eligible populations, qualified entities, qualification standards, and federal matching funds.

Presumptive Eligibility Toolkit

Enroll America developed a Presumptive Eligibility Toolkit for Hospitals to help connect eligible patients to Medicaid. Key sections of the toolkit include:

- Federal laws and regulations
- Working with your Medicaid agency
- Financing
- Ensuring ongoing Medicaid enrollment

Enroll America existed from 2013-2017 to increase enrollment and access to healthcare for uninsured Americans. Enroll America’s materials have since been incorporated into the Families USA website.
MEASURE PROGRESS

Data is the single most important aspect of your EEPNC quality improvement initiative, and defining and refining your data collection process throughout implementation is critical. Data collection should not be a burdensome process but rather a process that will highlight the most important issues to focus your clinic’s intervention and improve outcomes.

Below are a few points on how to effectively measure progress:

- Refer back to Know Your Numbers and identify data to be collected, how it will be captured, by whom, and how often.
- Select quality measures that are applicable to your end goal and can be tracked over time (create forms and tracking tools that can be handle large data points and can be easily manipulated).
- Compare data collected at the end of your project to baseline data collected during Know Your Numbers.
- Develop reports of trends and communicate finding to staff and key leaders within your organization.

Measuring your progress and knowing your data will help inform and motivate your staff to keep moving toward the end goal and increase early entry into prenatal care.

RESOURCES FOR IMPLEMENTATION

CDC Program Performance and Evaluation Office

The Centers for Disease control and Prevention’s Program Performance and Evaluation Office includes a number of resources to help you measure your progress. Helpful links include the following:

- Evaluation workbooks, documents, and tools
- A self-study guide and introduction to program evaluation
- Hints for conducting strong evaluations
- Upcoming CDC-led evaluation trainings and events
CDC Community Health Improvement Navigator

The Centers for Disease control and Prevention’s Community Health Improvement Navigator website includes a range of resources to develop and evaluate community health initiatives such as programs to increase early entry into prenatal care. In the Evaluation Actions section, you can find definitions of key concepts in evaluation and tools to get started.

The Community Tool Box

The Community Tool Box includes chapters and a toolkit dedicated to program evaluation, measuring progress, and sustaining momentum. Particularly helpful resources include the following:

- Introduction to evaluation
- Developing an evaluation plan
- Using evaluation to understand and improve the initiative
- Maintaining quality performance
- Evaluating the initiative toolkit

Quality and Safety in Health Care Journal

The journal BMJ Quality and Safety published an article titled Methods for Evaluation of Small Scale Quality Improvement Projects. This short academic journal article can help you as you plan and execute your evaluation plan for your quality improvement initiative. Methods discussed in the article may be particularly helpful if your initiative is small or in a pilot stage.
5 CASE STUDIES

In this section we present three case studies from clinics in Texas that undertook quality improvement initiatives to increase early entry into prenatal care (EEPNC). Case study clinics include:

- Legacy Southwest Clinic, Houston, TX
- CentroMed, San Antonio, TX
- University Health System, San Antonio, TX

Each clinic utilized different tools and engaged in different activities to assess EEPNC and to create change. We match activities to the sections in this resource guide where appropriate. We aim to provide real world examples of how these resources can come together in different combinations to fit unique clinic contexts and to ultimately increase early entry into prenatal care.

5.1 LEGACY COMMUNITY HEALTH SOUTHWEST

Legacy Community Health Southwest Clinic is a Federally Qualified Health Center (FQHC) located in the Gulfton community in southwest Houston. Ninety-seven percent of Legacy patients are Hispanic, and 93% are Spanish-speaking only. The literacy rates among patients are low, and most patients are classified as low-income. The majority of patients at Legacy qualify for Children’s Health Insurance Program (CHIP). Approximately 425 prenatal patients per week are seen at Legacy Southwest Clinic. In 2011, Legacy undertook a quality improvement initiative to assess and increase early entry into prenatal care in their clinic.

Develop Quality Improvement Infrastructure

Quality improvement team. Legacy’s Medical Director championed the EEPNC quality QI team. He assembled a small team of clinic leaders and staff to assess EEPNC and to direct quality improvement activities. These members included the following clinic providers and staff:

- Women’s Health Nurse Practitioner
- Director of Health Promotion
- Obstetrics and Gynecology MD
- Obstetrics Nurse Manager
- Patient Educator
**Mission.** Legacy’s quality improvement team used the clinic network’s overall mission and vision statement as their own mission and vision statements for the quality improvement project. Legacy’s mission statement and vision statements are succinct descriptions of their commitment to access to care.

**Mission**
Driving healthy change in our communities.

**Vision**
Connecting our communities to health every day, in every way.

*Understand the need*

**Baseline numbers.** Legacy staff completed a detailed chart review to examine early entry into prenatal care. The team randomly sampled 428 charts and identified women who received their first prenatal visit prior to 90 days of gestation from the last menstrual period (equal to or less than 12 6/7 weeks) between March to May 2011. They found that only 36.2% (155/428) of patients had first trimester care during that time period.

**Barriers.** A multidisciplinary team conducted patient interviews to understand obstacles to obtaining care. Barriers identified included the following:

- Language barriers
- Lack of childcare
- Inability to obtain a pregnancy test
- Lack of transportation
- Conflict between work hours and clinic service hours

Armed with this knowledge, the Legacy team developed a plan for quality improvement and developed strategies for increasing patients’ access to care.

*Increase access to care*

**Marketing.** Legacy developed a graphic illustrating their Path to Wrap-Around Care model (Figure 5.1). The graphic illustrates each step clearly and concisely helping patients understand the process for entering care. The graphic is available to patients online and in the clinic.

Legacy also developed a robust social marketing campaign advertising their services and the importance of prenatal care. All social marketing materials (Figures 5.2, 5.3) were available in English and Spanish.
Free pregnancy tests. Legacy began offering free pregnancy testing after women expressed concerns about obtaining tests. New administrative processes aimed to link women to care as soon as possible, and offering free pregnancy tests meant that Legacy could schedule women for their first prenatal appointment as soon as she had a confirmed pregnancy. Legacy’s front desk staff, eligibility department, and newly appointed patient navigator worked together to ensure a smooth process for patients. Flyers and postcards advertised free pregnancy testing hours at the clinic.

Longer hours. Originally, Legacy operated Monday to Friday, 8:00am to 4:30pm. However, patients noted that clinic hours were a consistent problem, and they were not convenient for before work or after work appointments. To make services more convenient, Legacy extended their hours. Obstetric and prenatal care hours are now Monday to Friday, 7:30am to 7:00pm and Saturdays from 9:00am to 4:00pm. Free pregnancy testing can also be done on Sundays from 12:00pm to 7:00pm. Legacy also doubled the number of OB providers and medical assistants and added an additional ultrasound technician. After noticing a high volume of high-risk patients, Legacy also added OBGYN specialists to services offered in their high-risk clinic.

Patient navigator. Patients cited language and health literacy as barriers to entering care. To help patients, Legacy hired a bilingual patient navigator focused on helping women navigate the eligibility process and healthcare system. Legacy’s patient navigator works closely with all departments to ensure a positive and seamless experience for patients.

Some of her duties included:

- Immediately assisting patients with positive free pregnancy tests
- Educating patients about Legacy’s services and about the importance of prenatal care
- Helping to schedule patients for same-day appointments using presumptive eligibility
- Registering mothers for maternity classes
- Collaborating with providers to identify high risk patients; linking patients with hospital
- Following up with patients regarding questions, concerns, and future appointments
Presumptive eligibility. Harris County has one of the highest rates of uninsured residents in the nation. Because of the ever-changing complexity of applying and receiving healthcare benefits, many eligible residents are not receiving coverage. This process can furthermore leave a strain on healthcare systems and community resources. In 2011, Harris County Healthcare Alliances partnered with local Harris County member clinics to implement Medicaider™, an eligibility screening system, to increase coordination or care among Harris County primary care patient. Legacy Southwest Clinic, as one of its partners, implemented this web-based system in order to more effectively and accurately screen uninsured patients for coverage.

Measure progress
Legacy’s quality improvement initiative was successful as the clinic increased the proportion of women entering prenatal care during their first trimester. After implementing quality improvement initiatives, 71.5% of women entered prenatal care during the first trimester compared to 36.2% (155/428) prior to the initiative (p<0.001). and to address patients’ needs at the clinic. The Legacy team presented their data at the American College of Obstetricians and Gynecologists District XI and Texas Association of OB/GYN Annual Meeting in September 2012.
5.2 CENTROMED

CentroMed is Federally Qualified Health Center with 19 clinic sites located across San Antonio, Texas serving a predominantly Hispanic population. Clinic sites include 16 primary care clinic sites and 3 obstetrics sites. In 2016, CentroMed partnered with the March of Dimes to assess early entry into prenatal care rates and to address barriers to care with data-driven solutions.

Develop quality improvement infrastructure

Quality improvement team. CentroMed had six standing quality improvement committees. Led by the Vice President & Chief Population Health Officer, clinic leadership added an ad hoc committee to address early entry into prenatal care in 2016. Other EEPNC quality improvement leaders included the Vice President of Development and Marketing, the Director of Women’s Health, the Obstetrics Nurse Supervisor, and other members of the women’s health team.

Mission. CentroMed’s quality improvement team focused on proactive measures to ensure healthy outcomes for both mothers and babies. The team focused on using real time data to assess trends, drive goals, and evaluate their efforts. Throughout the quality improvement initiative, the team consistently referred to the overall CentroMed mission and vision statements as succinct reminders of the importance of their work and of importance of quality customer service and care for patients.

Mission
CentroMed is an integrated primary care clinic that provides accessible services of superior quality

Vision
CentroMed will be a Premier Primary Care Clinic recognized for quality customer service, clinical excellence, comprehensive care, and responsiveness to community needs

Understand the need

Baseline numbers. CentroMed regularly reports early entry into prenatal care numbers for their clinic system as part of the Health Resources and Services Administration Uniform Data System (UDS) reporting requirements. In 2015, 62% of prenatal care CentroMed patients entered into care during their first trimester. Most prenatal care patients were ages 25-44 years (60%), followed by patient’s ages 20-24 years (30%), and those ages 15-19 years (10%). The team aimed to increase the early entry rate to the Healthy People 2020 goal of 77.9% within 12 months.
Barriers. With their mission and vision statements in mind, CentroMed focused on identifying and addressing internal barriers to care such as systems and processes that did not reflect their values of quality customer service for patients and clinical excellence. To understand barriers, the team sought to “deconstruct” and “dissect” their systems to identify how, when, and where patients made first contact with clinics and how CentroMed could streamline and accelerate processes to improve access to care.

For example, the team asked:

- What are the steps if a woman has a positive free pregnancy test?
- What are the steps if a woman calls our appointment line to set up an OB appointment?
- How long does it take for her to obtain an initial appointment?
- Who are the players involved in that process?
- What follow up occurs if she does not attend the appointment?
- How is this documented?
- How can we use this data to improve systems?

The team systematically assessed appointment scheduling processes for newly pregnant patients. They noted that the nurse practitioner (NP) conducting family planning appointments was also responsible for the obstetrics intake appointments for newly pregnant patients. Also, the team analyzed time between patient appointments—for example, the amount of time between a patient’s initial obstetrics intake appointment with the NP and her appointment with the physician. The team discovered women waited 27 days on average between the two appointments. Clinic leadership and the quality improvement team met and agreed this wait time was unacceptable and change was critical. When assessing this time lag, the team also identified another barrier. Patients who did not attend obstetric physician appointments were not always appropriately tracked, and some did not receive follow up calls to assess why they missed their appointments. Reducing time between appointments and tracking patients after missed appointments became key goals for the quality improvement initiative.

Increase access to care

Systems. The quality improvement team revamped their scheduling processes and systems for pregnant patients. First, CentroMed implemented an obstetrics/gynecology appointment line with a live nurse to schedule the appointments. This was separate from the appointment line for other patients.
Patients received **text message reminders** seven days prior to their appointments and every few days up until the appointment time. Patients have the opportunity to reply to the text reminders with a confirmation or cancellation. For those that cancel appointments, nursing staff follow up with patients to assess reasons for cancellation and to reschedule appointments.

To help reduce delays between appointments, CentroMed expanded the obstetrics intake appointment ledger. The nurse practitioner continued to split her time between family planning appointments and obstetrics intake appointments. However, instead of being split 50/50, the ledger was adjusted to accommodate more intake appointments and less family planning appointments. This was based on data and trends in appointment volume identified during the assessment phase.

**Quality improvement champions.** CentroMed is committed to ongoing quality improvement. To ensure the ad hoc quality improvement team’s successes continue, the team identified champions to ensure sustainability. Currently, the Women’s Health Director and Obstetrics Director ensure early entry into prenatal care remains a top priority for CentroMed with regular meetings and data monitoring. The champions are also maintain transparency with clinic leadership reporting trends and alerting leadership when data reveal the need for additional systems changes.

**Measuring progress**

CentroMed has a robust reporting process to ensure they measure progress and maintain successes. Clinic champions and leadership continue to monitor the proportion of patients entering care during their first trimester monthly to track trends. Additionally, the team focuses on process-related questions to ensure systems remain successful. For example, they track and assess appointment times and ask “does the obstetrics appointment ledger need to be adjusted?” They also track patient cancellations and reasons based on text message replies and staff follow ups with patients. Using this combination of electronic medical record data and process-related data, CentroMed evaluates their efforts to ensure they provide ongoing quality care and customer service to their patients throughout San Antonio.
5.3 UNIVERSITY HEALTH SYSTEM

University Health System (UHS) is a teaching hospital and network of outpatient health centers located in San Antonio, Texas. The network includes 13 community-based clinics delivering primary care and specialty care including obstetrics to San Antonio residents. Similar to CentroMed, UHS partnered with the March of Dimes in 2016 to assess early entry into prenatal care in their clinics and to address barriers to care experienced by their pregnant patients.

UHS has a unique patient population in that they serve a significant refugee population. To ensure communication with patients is not a problem, UHS has a number of translators and a translation call line to use when engaging with patients. They are therefore able to communicate with patients in almost any language or dialect to ensure all patients receive quality, comprehensive care. Translation services are critical to ensuring patients feel comfortable and welcome in the UHS clinics.

Develop quality improvement infrastructure

Quality improvement team. UHS leadership charged the quality improvement team with identifying and addressing patient barriers to care, streamlining systems, and ensuring retention of patients throughout prenatal care and postpartum. The quality improvement team included Women’s Health team members, the Director of Women’s Health, nurse supervisors, nurse educators, the Senior Quality Data Analyst, and the Training and Call Quality Manager.

Make it your mission

The quality improvement team focused on identifying and addressing patient barriers to care. Similar to Legacy and CentroMed, the team was driven by the system’s overall mission and vision statements.

Mission
To promote the good health of the community by providing the highest quality of care to both inpatients and outpatients, by teaching the next generation of health professionals, and by supporting research thereby advancing medical knowledge and improving the delivery of patient care.

Vision
We will continuously improve the health and well-being of the people of Bexar County, South Texas, and beyond.
Understand the need

**Barriers.** One of the quality improvement teams primary goals was to identify and document patient barriers to care throughout the quality improvement process to understand how they could adapt and improve systems. Quality improvement team members spoke with staff and heard stories anecdotally about patient barriers and the reasons women may leave care. UHS also implemented new systems to document barriers (see Improve Access to Care).

A significant barrier for women included lack of insurance and funding for care. Other barriers included transportation, clinic and hospital proximity, long wait times, and lack of childcare during appointment times.

Increase access to care

**Standardized systems.** UHS had an efficient call center for patients prior to the EEPNC quality improvement initiative. Call center operators were quick to answer calls—typically in less than one minute, and calls lasted 1-3 minutes to schedule patient appointments which usually happened within 10 days from the call. To increase early entry into prenatal care, UHS added a call tree for operators devoted solely to women’s health patients. Because insurance and funding was often a barrier for patients, the call tree immediately linked women who lacked funding to CareLink, UHS’s financial assistance program. UHS also standardized guidelines for women calling the women’s health line. Guidelines stated that new obstetrics patients needed to be seen within one week of their initiation call.

**Patient navigators.** UHS includes both community clinics and a hospital. Patient navigators have been integrated in the clinics since 2007. Navigators regularly monitor clinic appointment schedules and identify new patients. Navigators call new patients 1 to 2 days prior to their appointment. During that call, the navigators identify potential challenges for the patient accessing care, and she works with the patient to identify solutions. For example, if transportation is a barrier, UHS offers free bus passes. Patient navigators also follow up with patients at specific times throughout their pregnancy to ensure they continue prenatal care.

Although the clinics have had patient navigators since 2007, navigators were not a part of the UHS hospitals prior to the quality improvement initiative. As a part of the initiative, UHS placed inpatient navigators in the hospital to assist patients who enter the gynecology emergency center or hospital emergency department. As soon as a patient is identified as pregnant, inpatient navigators provide her with a document that contains a list of UHS clinics and the women’s appointment line phone number to schedule her first prenatal care appointment.
Other changes to the patient navigator system at UHS included improved documentation of barriers and a stronger partnership with CareLink. UHS leadership was committed to understanding and addressing patient barriers to care, and they developed a new documentation and reporting system for patient navigators to use to identify patient barriers to care. Documentation included reasons women chose to leave care at UHS and move to another system. Navigators would call patients to identify why they did not attend appointments, document reasons, and encourage them to return. Because funding was a common barrier to accessing care, patients who had a positive free pregnancy test were immediately linked with the patient navigator. Prior to the quality improvement initiative, women obtained their pregnancy results and scheduled an appointment without speaking with a navigator. These new systems helped with patient retention and assessment of barriers.

**Measuring progress**

UHS leadership and the quality improvement team remain committed to improving early entry into prenatal care in their clinics. Along with tracking the numbers of women who enter into care, UHS identified an important metric for ensuring they provide superior care: patient satisfaction. UHS now regularly texts patients with a brief, bilingual, three-question survey asking about the quality of the care the patient received. This system allows UHS to identify areas for improvement and to ensure they are responsive to patient needs. Combined with patient rates of entry into care, this data paints a unique picture of patient needs so that UHS can continue to improve systems and provide the highest quality care possible.
6 CONCLUSION

Increasing prenatal care as a quality improvement initiative requires engagement of the community, your clinic, and your patients. This resource guide aimed to help you facilitate early entry into prenatal care and to improve pregnancy outcomes for your patients. We know that moms and babies benefit from your commitment to developing strong quality improvement infrastructure, understanding the unique needs of your community, and increasing access to care.

Contact March of Dimes for additional information on any of the programs and initiatives discussed in this guide or to suggest innovative strategies you employ in your clinics to ensure the best care for moms and babies.

We are excited to have you join us in our commitment to healthy moms and strong babies.

WWW.MARCHOFDIMES.ORG
Identify QI Champions:
- Ideal: clinic leader, QI nurse, OB/GYN chair, and/or project sponsor

QI Champions meeting:
- Review Early Entry into Prenatal Care Resource Guide
- Plan for baseline data collection (Section 2.1—Know Your Numbers)
- Identify additional QI team members to recruit
  Team members may include:
  - medical director
  - physicians assistants
  - physicians and nurses
  - patients and/or patient representatives
  - nursing Staff
  - community health workers
- Develop quality improvement goals (Section 1.2—Make it Your Mission)

QI Team meeting:
- Review and refine quality improvement goals
- Review plan for baseline data collection
- Review Early Entry into Prenatal Care Resource Guide
- Develop quality improvement initiative timeline
- Establish regular meeting schedule
General clinic information

Individual completing this form:

Clinic Name:

Address:

Hours of Operation:

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Medical Director:

Total Number of Physicians: ________  Total Number of Nurses: ________

Total Number of Medical Assts:  Total Number of Physicians Assts:

Existing processes

How are patients scheduled when they contact your clinic and how long does the process typically take? Is there a scheduling system you use? Who schedules patients?

________________________________________________________________________

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Do you have existing flow charts or process maps for your women’s health programs? Describe this process. Provide any documentation you think may be relevant to understand your system of care.

Successful systems

Describe up to three interventions or systems in place at your clinic that are successful at encouraging women to seek early prenatal care. Be as specific as possible on why you think these are successful.

1.

2.

3.
To what extent does your clinic implement the following to promote early entry into prenatal care? Place an X where appropriate.

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<th></th>
<th>Fully implement</th>
<th>Somewhat implement</th>
<th>Early stages of implementation</th>
<th>Planning to implement</th>
<th>Not implemented</th>
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<tbody>
<tr>
<td>Have a quality improvement team focused on early entry into prenatal care</td>
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<td>Incorporate quality improvement as part of our mission statement</td>
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<td>Have clear channels of communication for quality improvement</td>
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<td>Regularly assess early entry into prenatal care</td>
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<td>Regularly assess patient barriers to care</td>
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<td>Engage with community partners to increase access to care</td>
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<td>Measure our progress related to early entry into prenatal care</td>
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Quality Improvement Needs

List three priorities at your clinic for increasing early entry into prenatal care. These may include implementing new interventions, strengthening existing systems, etc.

1. 

2. 

3. 

Quality Improvement Team

Name: ____________________________
Title: ____________________________
Phone: ____________________________
Email: ____________________________

Name: ____________________________
Title: ____________________________
Phone: ____________________________
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Name: ____________________________
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## Develop quality improvement infrastructure

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<th>Resource Guide Component</th>
<th>How does the current infrastructure support quality improvement to increase EEPNC?</th>
<th>What additional steps will you take/did you take to strengthen infrastructure?</th>
<th>Who will implement these activities?</th>
<th>How are activities being implemented/conducted? E.g., flow chart, check list, outline of procedures to follow</th>
<th>Successes and/or barriers to implementing activities so far</th>
<th>Additional resources needed</th>
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<td>Establish a Quality Improvement Team</td>
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<td>Make It Your Mission</td>
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<td>Establish Clear Communication Channels</td>
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<td>Other activities to develop/strengthen infrastructure:</td>
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## Understand the need

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<td>Know Your Numbers</td>
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<td>Know the Barriers to Care</td>
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<td>Know Your Community Partners</td>
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## Increase access to care

<table>
<thead>
<tr>
<th>Resource Guide Component</th>
<th>How does the current infrastructure support quality improvement to increase EEPNC?</th>
<th>What additional steps will you take/did you take to strengthen infrastructure?</th>
<th>Who will implement these activities?</th>
<th>How are activities being implemented/conducted? (e.g., flow chart, check list, outline of procedures to follow)</th>
<th>Successes and/or barriers to implementing activities so far</th>
<th>Additional resources needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Your Services</td>
<td></td>
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<td></td>
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<tr>
<td>Provide Free Pregnancy Tests</td>
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<tr>
<td>Establish Patient Navigator Position</td>
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<tr>
<td>Utilize Presumptive Eligibility</td>
<td></td>
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</tr>
<tr>
<td>Other activities to increase access to care:</td>
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</tr>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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</tr>
</tbody>
</table>
## Overall Goal:

[Blank line]

## SMART Objectives:

<table>
<thead>
<tr>
<th>S</th>
<th>Specific — What do we want to accomplish? Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Measurable — How do we quantify/measure progress? Success?</td>
</tr>
<tr>
<td>A</td>
<td>Achievable — What logistical steps are needed? Resources?</td>
</tr>
<tr>
<td>R</td>
<td>Relevant — How does this improve access to early prenatal care?</td>
</tr>
<tr>
<td>T</td>
<td>Time-bound — What is the deadline?</td>
</tr>
</tbody>
</table>

## SMART Objectives:

<table>
<thead>
<tr>
<th>S</th>
<th>Specific — What do we want to accomplish? Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Measurable — How do we quantify/measure progress? Success?</td>
</tr>
<tr>
<td>A</td>
<td>Achievable — What logistical steps are needed? Resources?</td>
</tr>
<tr>
<td>R</td>
<td>Relevant — How does this improve access to early prenatal care?</td>
</tr>
<tr>
<td>T</td>
<td>Time-bound — What is the deadline?</td>
</tr>
</tbody>
</table>
## APPENDIX E - ABBREVIATED DATA LOG

### A

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 15</td>
<td></td>
</tr>
<tr>
<td>15-19 years</td>
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</tr>
<tr>
<td>20-24 years</td>
<td></td>
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<tr>
<td>25-44 years</td>
<td></td>
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<tr>
<td>45 years and over</td>
<td></td>
</tr>
<tr>
<td><strong>Total Patients</strong></td>
<td></td>
</tr>
</tbody>
</table>

### B

<table>
<thead>
<tr>
<th>Trimester of Entry</th>
<th>Women having first visit with clinic</th>
<th>Women having first visit with another provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Trimester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Trimester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Trimester</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### C

**Proportion of PNC patients entering care in first trimester:**

Numerator = Line 7, Columns B + C  
Denominator = Lines 7 + 8 + 9, Columns B + C  

Adapted from HRSA Uniform Data System Reporting System
Appendix F - Individual and Environmental Barriers Logic Model

Individual reasons/beliefs/attitudes that may influence mothers to delay care:

Behavior: Mothers do not access prenatal care early in pregnancy

Environmental Level: Environmental factors that negatively impact mothers’ access to early prenatal care and/or negatively impact mothers’ decision to enter prenatal care early

- Interpersonal – (Ex: doctor, family)
- Clinic-level – (Ex: clinic hours, lack of childcare)
- Community-level – (Ex: transportation, social norms)
<table>
<thead>
<tr>
<th>Sector</th>
<th>Contact Name</th>
<th>Organization</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-based</td>
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<td></td>
<td></td>
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<tr>
<td>organizations</td>
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<td></td>
</tr>
<tr>
<td>Education</td>
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<tr>
<td>Faith-based</td>
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<tr>
<td>organizations</td>
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</tr>
<tr>
<td>Business</td>
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<tr>
<td>Government</td>
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<tr>
<td>agencies</td>
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<tr>
<td>Consumer groups</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>
Objectives:

1. Pretest program materials to understand perceptions of the key messages and to determine appeal, appropriateness, and cultural relevance
2. Determine how pregnant mothers (primary target) and community members understand the materials’ key messages
3. Understand how community members communicate about materials’ key messages
4. Ensure materials’ key messages align with health messages conveyed by providers

Key questions:

Each piece of material should be broken into small sections. This allows the focus group members to focus on smaller chunks to give specific feedback on, and it allows March of Dimes to pinpoint exactly what group members are responding to and what needs to change. Questions to consider include the following:

- Tell me, in your own words, what this section says. What is the message?
- If this message were told to your community, would a woman follow these suggestions? Why? Why not?
- Is there anything in this section that you don’t believe is true?
- Is there a different way to say this? How would you say this?
- Is there anything in this section that might bother or offend you or your friends?

Other questions include:

- What first caught your eye in this poster/flyer/card/etc.? Once seeing this, did you want to keep reading?
- What is the overall message? How would you say it?
- Looking at the images, would you believe the women in these pictures?
- Would you change the pictures in this poster/etc.? How?
- What, in particular, do you like about this poster/etc.?
- What would you do to make this poster/etc. better? Do you think anything is missing?
- What information did you already know? What did you learn?
Coordinates care of OB patients before and after delivery

a. Demonstrates knowledge and utilizes experience in the care of OB patients;
b. Assists patients and their families in understanding their plan of care;
c. Performs OB screens, coordinates OB tours, and hospital registration;
d. Coordinates patient referral to support services (e.g., specialty referrals, social services, nutritional, dental, etc.) provided through clinic network or community partners;
e. Assists in scheduling required procedures and ensures laboratory tests are completed in a timely manner;
f. Recognizes patterns/trends predictive of patient condition changes and indicative of interventions required;
g. Communicates with physicians regarding patient condition and disposition and documents events appropriately;
h. Communicates effectively with patients and patient’s family/significant others; and
i. Acts as a liaison to enhance quality and continuity of care.

Provides individualized support to patients serving as their resource and advocate

a. Follows-up on missed appointments;
b. Collaborates with other healthcare team members regarding patient care and clinical issues;
c. Advocates for appropriate, equitable patient/family care designed to meet unique patient needs;
d. Ensures that women have full, equitable and convenient access to the clinical services they require and to the women sensitive health education information needed to make informed decisions about their care; and
e. Provides emotional support on the patients’ journey to parenthood.

(continued)
Participates in quality improvement, research processes/utilization and community activities as appropriate

a. Participates in data collection, centering data, tracking of non-centered patients and monitoring of patient volume;
b. Identifies problems and applies generated information to health care practice with the goal of improving utilization and clinical outcomes;
c. Effectively applies the PDCA quality improvement process in engaging staff in quality improvement activities;
d. Utilizes research in creating and promoting practice changes.
e. Uses an evidence-based, clinical inquiry approach to evaluate conventional practices associated with assigned specialty population; recommends or initiates change when indicated.
f. Recognizes and documents patterns as a basis for formulating evidence-based problem or need statements; uses evidence-based resources to interpret significance of findings and provide a foundation for possible solutions.
g. Participates in one or more of the following clinical inquiry activities: quality improvement, evidence-based resource development, change initiatives, or translational research.
h. Uses standard evidence-based approach in conducting clinical inquiry; uses PICO format in developing problem statement.
i. Uses evidence-based approach to facilitate individualization of standards and guidelines for particular patient situations or populations.
j. Participates in community outreach activities.
k. Assists in planning and implementing related programs;
l. Sets-up OB specific education booth in Center Health Fairs;
m. Develops alternative methods of marketing/outreach/promotion;
n. Engages in external community outreach events; and
o. Collaborates with Community Health Workers and external stakeholders

(continued)
Models professionalism

a. Fully engaged as a member of the Community of Practice.
b. Demonstrates a commitment to continuous, lifelong learning and education for self and others; uses self-reflection and inquiry in advancing individual growth.
c. Contributes to resolving ethical issues involving patients/families, colleagues, community groups, systems and other stakeholders; uses self-reflection and inquiry in advancing individual growth.
d. Takes appropriate action regarding instances of illegal, unethical, or inappropriate behavior that can endanger or jeopardize the best interests of the patient or situation.
e. Speaks up and uses appropriate channels to address healthcare practice indicative of need for safety and quality improvement.
f. Teaches nursing staff and students in application of ANA Code of Ethics to clinical situations.
g. Acquires knowledge and skills appropriate to the role, assigned specialty population, and clinical setting.
h. Seeks formal and independent learning opportunities and experiences.
i. Shares educational findings, experiences, and ideas with peers.
j. Serves as a resource in educating nursing students, residents, medical students, and new employees.
k. Facilitates a work environment conducive to clinical learning and professional growth.

Patient satisfaction

a. Works collaboratively with colleagues to deliver patient/customer services that meet or exceed patient expectations as evidenced by patient satisfaction scores.