



Building Prenatal Care Capacity: A Community Report

COUNCIL ON HEALTHY MOTHERS AND BABIES

May 2008

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Executive Summary

Over the past 15 years, the Council on Healthy Mothers and Babies (COHMAB) has worked to improve prenatal care access in Franklin County, Ohio. Efforts have included studying the amount of time a woman must wait to obtain an initial prenatal care appointment at the public OB clinics and determining barriers to accessing prenatal care. A major barrier is the lack of awareness among women with Medicaid or no insurance on how to access prenatal care. To address this access barrier, the COHMAB created a centralized scheduling program for initial prenatal care appointments called Pregnancy Care Connection. Beyond providing access to prenatal care, Pregnancy Care Connection's goal is to reduce the wait time for initial prenatal care appointments.

Despite the fact that Pregnancy Care Connection has had an impact on prenatal care access, the wait time for appointments continues to increase. This rise in waiting time is attributed to the decline in capacity for prenatal care appointments. **Between 2003 and 2004, there was a 31% decrease in available prenatal care appointments.** This decline was attributed to hospital-based clinics reducing the number of patient appointments due to the cap in resident work requirements; clinics experiencing an increase in the number of immigrant pregnant patients requiring longer appointments to address language and cultural barriers; and broader, overarching concerns regarding medical malpractice and liability issues for OB/GYNs resulting in fewer OB providers and future residents. This decline is the reason the Council on Healthy Mothers and Babies began to hold roundtables with physicians, OB clinic nurses, social workers, and key community leaders to address the issue of prenatal care capacity.

The purpose of the roundtables was to heighten awareness and devise solutions to curb the declining prenatal care capacity in Franklin County. The participants of the roundtables identified four areas to concentrate efforts to positively impact capacity: (1) raise public awareness on the importance of prenatal care and access to care; (2) impact the State of Ohio's budget to increase Medicaid coverage, ensure Medicaid reimbursement for interpretive services, and increase the Child and Family Health Services budget line item for local health departments and community organizations to provide health care and enabling services; (3) understand and address the specific needs of pregnant immigrant and refugee women; and, (4) advocate and obtain a waiver for family planning services to extend Medicaid coverage to more women.

While these valid and noble efforts have some impact on capacity, most of them tend to have a greater impact on access. Thus, more women may attempt to access prenatal care, but capacity is not increasing at the same rate to meet such a demand. **The prenatal care capacity crisis must be addressed by community, state, and national leaders who can increase availability of prenatal care for uninsured and Medicaid eligible women. These actions will require increased funding for clinics along with increased number of OB/GYNs to provide public prenatal care.**

Introduction

Julia C. Lathrop, Chief of the Department of Labor's Children's Bureau, stated in 1915 that "infant mortality is a subject of profound social importance. The modern view has ceased to be fatalistic; infant mortality is now regarded as a preventable waste."

Early entry into prenatal care is extremely important for improving birth outcomes. First trimester screening and testing are critical in identifying and intervening early to address problems that could be life long. The Healthy People Year 2010 Goal is 90% of women will obtain prenatal care in the first trimester. However, Ohio is far from reaching this goal as only 72.7% of women obtained prenatal care in the first trimester in 2006.

There are several reasons why women do not access early prenatal care, but one of the primary reasons is the lack of available prenatal care in their communities. In Franklin County and throughout Ohio, there has been a significant decrease in the capacity of public prenatal care which impacts access to early prenatal care.

Ninety-three years later, Julie C. Lathrop's statement remains true. Key community and state leaders must begin viewing prenatal care capacity as a critical social issue and crisis that must be resolved for all. Women with insurance, including Medicaid and uninsured deserve and require early and adequate prenatal care to positively impact birth outcomes.

History of Prenatal Care Access and Capacity Issues

The Council on Healthy Mothers and Babies (COHMAB), known then as the Franklin County Leadership Council to Reduce Infant Mortality, met for the first time in March 1992. The original convening leaders were Columbus Public Health (CPH), Nationwide Children's Hospital and March of Dimes. The goal was to reduce infant mortality in Franklin County, Ohio. One of the key strategies identified to assist in meeting this goal was to improve access to, capacity, and utilization of prenatal care. In fact, it was the prenatal care capacity issue that initiated a community wide campaign for action. Over the years, the COHMAB has measured and reported on waiting times for initial prenatal care appointments and worked to address barriers to prenatal care. Community task forces and action teams have worked together to improve public prenatal care access in Franklin County, including the development and implementation of a centralized scheduling program for initial prenatal care appointments called Pregnancy Care Connection (PCC). While progress had been made, challenges have remained and the work continues today.



Initial Prenatal Care Appointments Studies

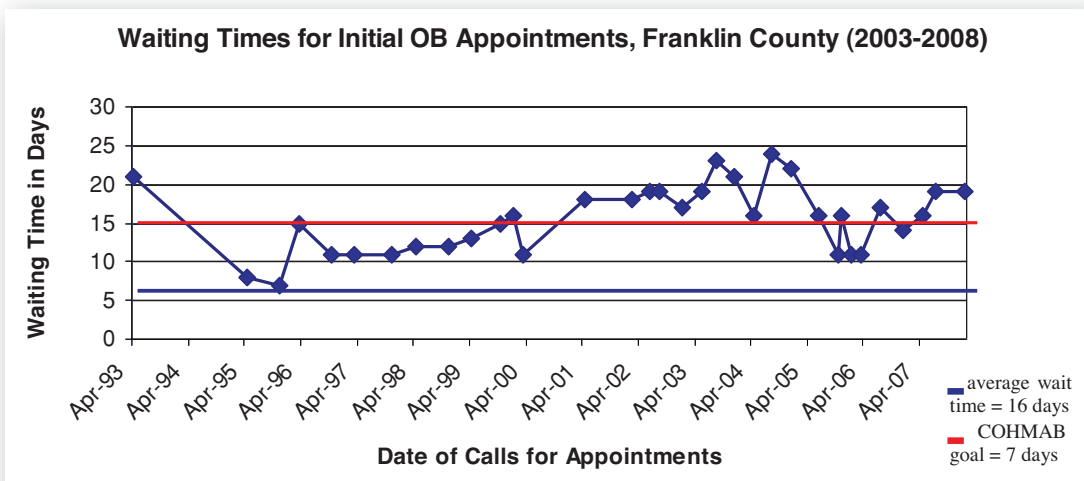
The lack of public prenatal care capacity in a community directly impacts a pregnant woman's entry into prenatal care. To increase the likelihood of positive birth outcomes, women need to receive prenatal care during the first trimester. Healthy People 2010 goal and Ohio Department of Job and Family Services goal is a woman wait no more than 5 days for a first prenatal care appointment. As a community, the COHMAB has set a goal that women are able to obtain an appointment for prenatal care within 7 days.

Initial Prenatal Care Appointments

- Average wait time is 16 days to see a clinician.
- Average number of women who do not show up to the appointment is 32.4%.
- The biggest reason for not attending the first appointment is the woman went somewhere else for care.

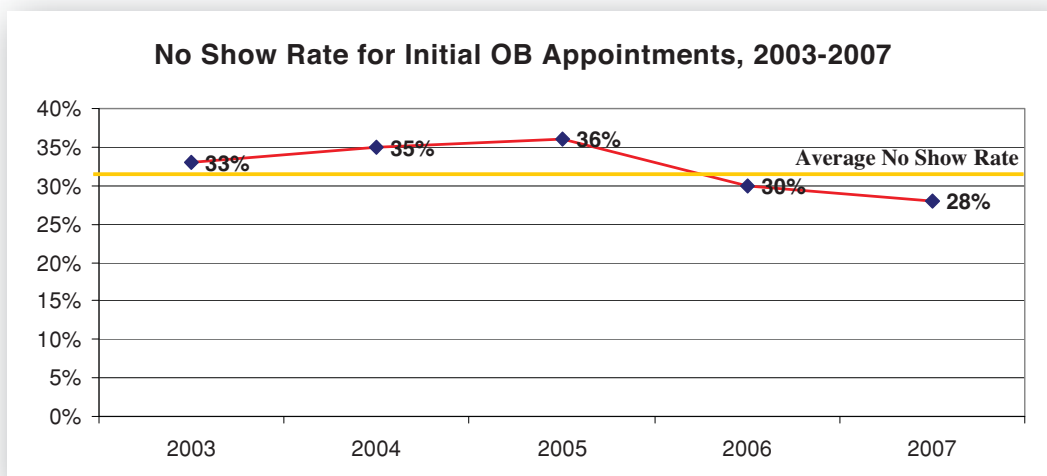
The COHMAB has been conducting wait time studies for initial prenatal care appointments since 1993. The public health providers for prenatal care in Franklin County are contacted by the caller pretending to be a pregnant woman needing care and asked when the next appointment would be available for a person with Medicaid or without insurance. Several studies have included a Spanish speaking caller requiring an interpreter.

Thirty-four studies have been conducted since 1993. The mean and median wait time in this fifteen year period is 16 days. The longest wait time has been 24 days (2004), with the shortest wait time being 7 days (1995). The chart below illustrates the average wait time for each study conducted between 1993 and 2008.



Further studies have found that the longer a woman has to wait for the initial prenatal care appointment, the more likely the woman will choose to go to another provider with a shorter wait time. Results of the wait time studies have been shared with public OB providers and the community, and action has been taken to address the waiting time for initial prenatal care.

The COHMAB has also asked the public OB providers to conduct annual surveys since 2003. The providers are asked to record for a month period the number of women who do not show for their initial prenatal care appointments, which results in a “no show” rate. The chart below illustrates the average no show rate for initial OB appointments between 2003 and 2007 is 32.4% with 36% being the highest and 28% being the lowest rate for no shows.



The COHMAB has conducted several follow-up studies with women who do not show for their initial prenatal care appointments. To date, **the number one reason for women not showing for their appointment is that they went somewhere else for care either due to being able to get in earlier or clinic preference (31%).** Other reasons included:

- women lacked transportation to the appointment (11%);
- miscarried (9%);
- came to the appointment late or unprepared (8%);
- moved out of town (5%);
- forgot about appointment (3%);
- and already delivered (3%).

Barriers to Care Surveys: Patients' Perspective

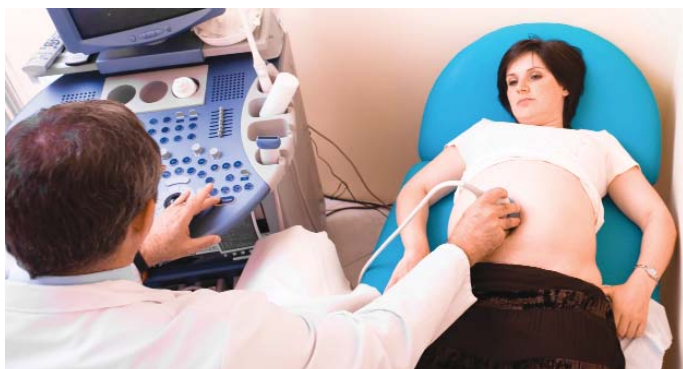
The Barriers to Care Survey, managed by the Columbus Public Health (CPH) Perinatal Project, further explores why women may enter prenatal care late. The CPH Perinatal Clinics have been conducting the survey, administered to all new OB patients, since the 1990s. In addition to collecting information on the leading barriers to care, the survey enables collection of demographic information including age, race and ethnicity, zip code of residence, and employment status. The CPH also assess modes of transportation/how women get to their PNC appointments, how long it takes to get to their appointments, and when the most convenient times for PNC appointments are for women. The surveys are provided in English, Spanish and Somali.

Starting in 2006, the Barriers to Care survey tool was further administered by some Franklin County public OB providers. The result of these Barriers to Care surveys indicate that, on average, **less than 1/3 (28%) of women in public OB clinics access prenatal care during their first trimester, which is considerably less than the 69.5% of women who entered care in their first trimester in Franklin County in 2006.**

Survey results further indicate that on average, over 30% of women believe it is difficult to get prenatal care. The leading barriers to care are listed below in order of frequency:

1. No money or health insurance (41%)
2. Hard to schedule an appointment (31%)
3. No Medicaid (26%)
4. Did not know where to call for care (22%)
5. Could not get an earlier appointment (20%)
6. No transportation (13%)

These results, in addition to the wait time and no show studies, confirm the need for a stronger community response to educate residents about the importance of early, regular prenatal care visits, and also the need for system changes to address and alleviate the most common barriers to prenatal care.





Pregnancy Care Connection (PCC)

One of the most successful system changes to occur in Franklin County to address and alleviate some barriers to public prenatal care is Pregnancy Care Connection (PCC). The development of PCC began in 2002 when CPH contracted with the COHMAB to conduct a feasibility study with each of the public OB providers in Franklin County to determine how each provider scheduled appointments and if there would be interest in developing a community based centralized scheduling system. Representatives from all of the hospital systems, neighborhood health centers, and CPH attended a joint meeting facilitated by the COHMAB to plan and design the centralized system.

In August 2003, PCC opened with a Spanish bi-lingual Intake Specialist operating the phone line. Its mission is to facilitate access to early prenatal care for all uninsured and Medicaid eligible women in Franklin County. The program is designed to provide women with one number to schedule their prenatal care appointment with the intent that there will be increased access to prenatal care during the first trimester, reduced wait times for appointments and reduced no shows for first prenatal care appointments.

The public OB providers for PCC which make up the PCC Advisory Committee include: Columbus Public Health East; Columbus Public Health North; Columbus Public Health West; Columbus Northeast Health Center; Doctors Hospital; East Central Health Center; Grant Medical Center; Hilltop Health Center; John Maloney Health Center; Mount Carmel St. Ann's Hospital; Mount Carmel West OB/GYN; OhioHealth Wellness on Wheels; OSU East Family Practice; OSU Medical Center OB/GYN; OSU Rardin Family Practice; Riverside OB/GYN Community Care; and St. Stephen's Health Center.

PCC has scheduled over 10,000 initial prenatal care appointments for pregnant women.

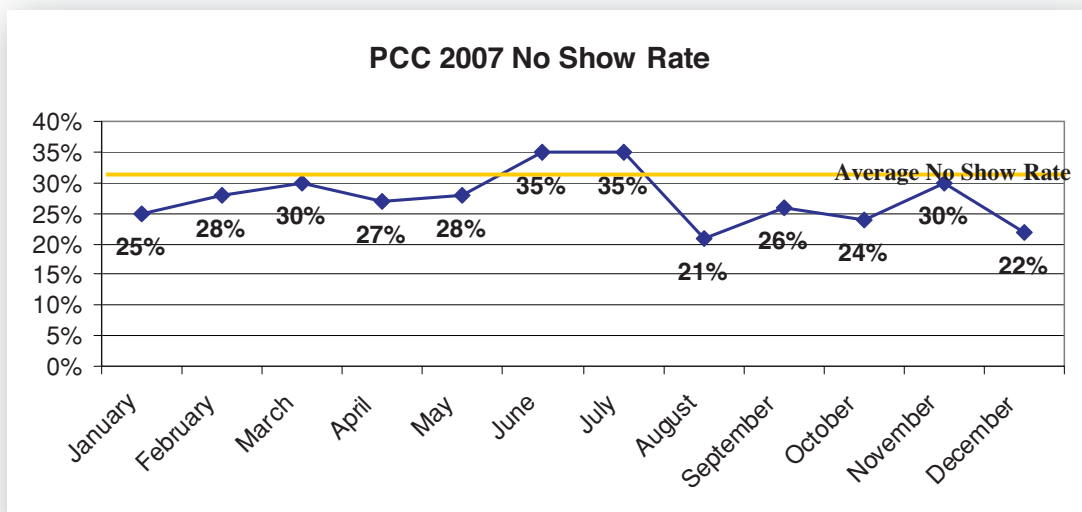
As of April 2008, PCC is able to schedule 76 initial OB appointments per week from sixteen of the seventeen contracted public OB providers scheduling through PCC. This is a 46% increase from the inception of PCC. This increase is attributed to adding new OB clinics along with current clinics allocating more appointments. PCC is now the sole scheduler for initial OB appointments for 4 providers: Columbus Public Health East, Columbus Public Health North, Columbus Public Health West, and OSU Medical Center OB/GYN.

As of April 2008, PCC has scheduled appointments for over 10,000 women.

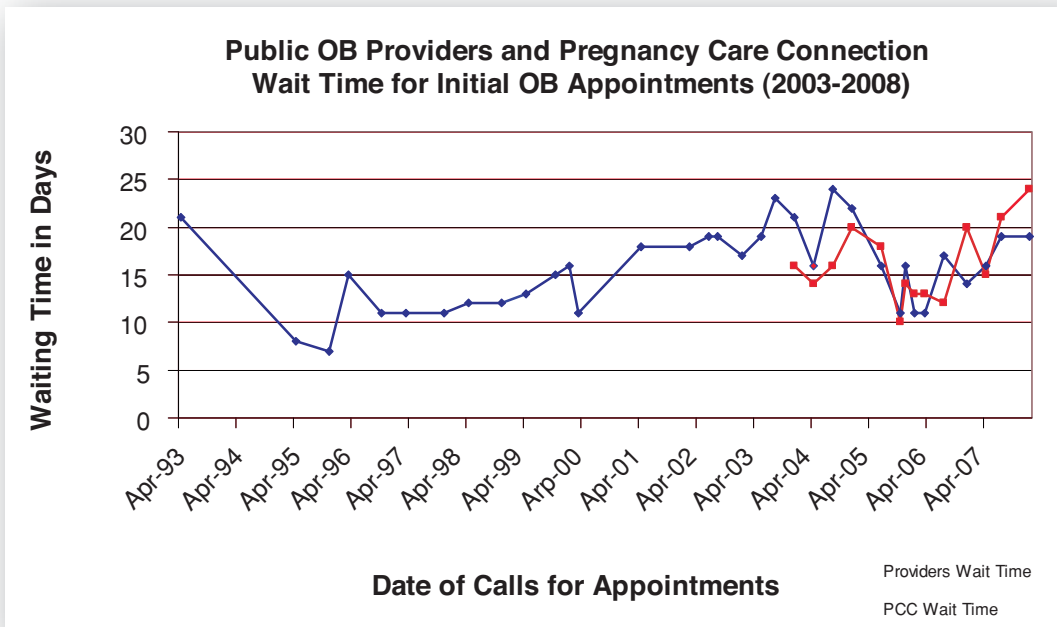
- Fifty-nine percent (59%) of these women enter care without insurance;
- 11.5% are minors; and almost 22% need an interpreter (16% Spanish, 3% Somali, 3% other languages).
- Forty percent (40%) of the women scheduling through PCC are Black/African American; 29% are White; and 19% are Latina.

A goal of PCC is to reduce the overall no show rate for appointments to 15%. By allocating as many appointments as possible to PCC, the likelihood of women accessing care through another clinic diminishes. To completely reach this goal, all public OB providers must allocate a significant portion, if not all, of the initial prenatal care appointments to PCC. As mentioned before, PCC is currently the sole scheduler for four clinics. However, a few clinics have reduced the number of appointments allocated to PCC over the past two years due to diminishing capacity and increasing volume.

PCC's no show rate is lower than the overall community's no show rate for initial prenatal care appointments as illustrated in the below chart. In 2007, PCC's no show rate averaged 27.5%, whereas the overall community's no show rate was 32.4%. In June and July 2007, the no show rate was higher due to several public OB providers not offering prenatal care during those months.



The wait time for initial OB appointments continues to be a concern in Franklin County. The PCC goal for the wait time is 7 days for an appointment. The wait time has remained steady around 16 days since PCC was created; however; PCC's wait time is slowly increasing and is often longer than the public OB providers' wait time. This is mainly attributed to the public OB providers capping the initial prenatal care appointment at 21 days, thus requiring women to seek care elsewhere. PCC often becomes the primary referral source from public OB providers that are full, thus causing PCC's wait time to increase. The reason for capping appointments and referring to PCC when full is due to the prenatal care capacity of Franklin County.



PCC will continue its efforts to increase the number of appointments allocated by public health providers, as well as work towards obtaining all initial intakes for PCC clinical providers. **The hypothesis is the more appointments that can be centralized, the greater likelihood the wait time and no show for initial OB appointments will decrease in the community.**

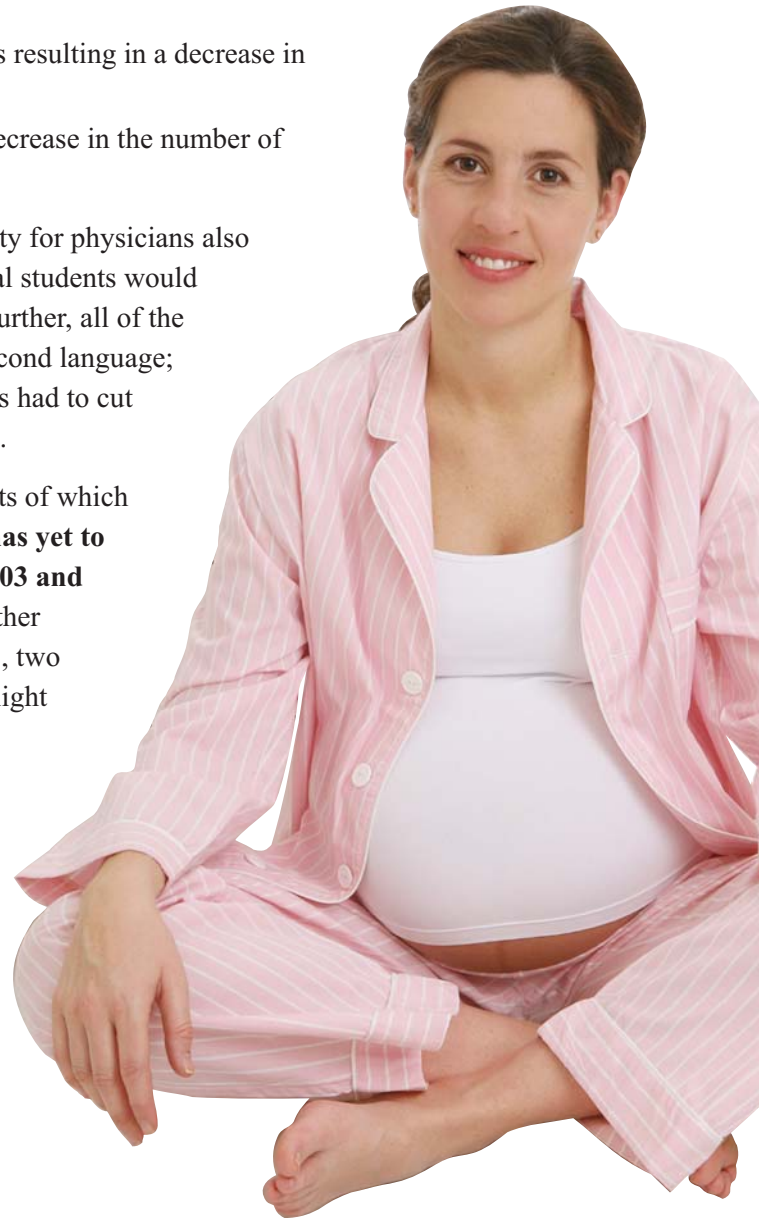
Prenatal Care Capacity Studies

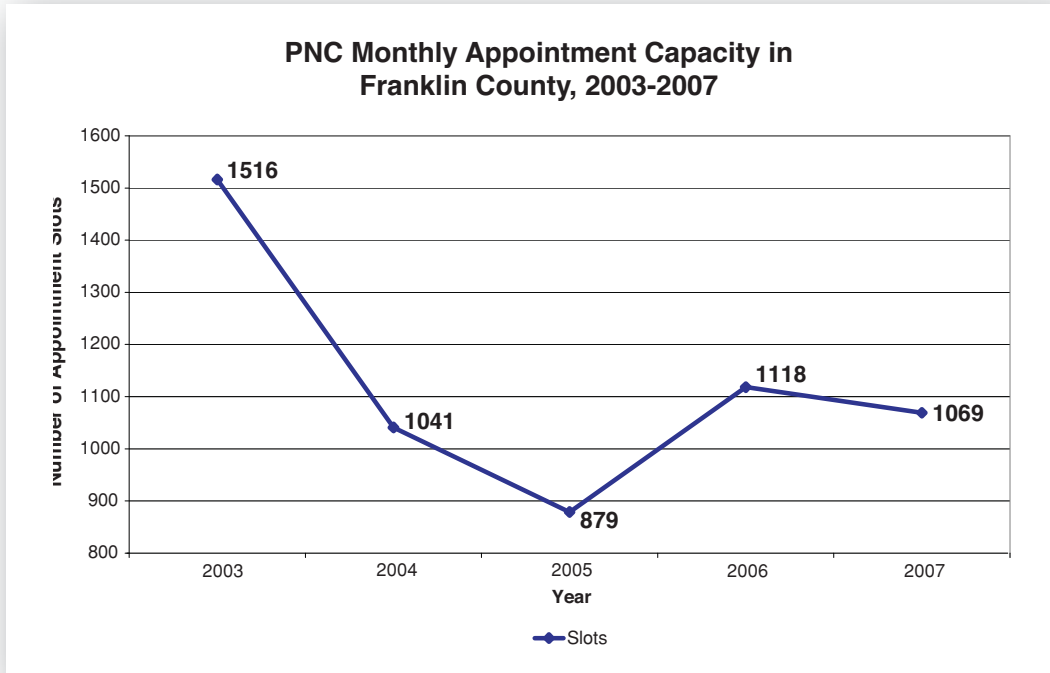
In order to ensure timely access to prenatal care, assuring adequate capacity is essential. The COHMAB has assessed overall public prenatal care capacity since 2003 and the results of this assessment are concerning. In May 2003 as part of the development of Pregnancy Care Connection, the Advisory Committee completed a survey and identified that the public health system had 1,516 initial prenatal care appointments available monthly. When this survey was repeated in April 2004, there were 1,041 appointments available, a decrease of 31%. The COHMAB worked with providers to identify the issues driving this decrease in capacity, which included the following:

1. The local health department's prenatal care program, funded by the State, experienced a 29% decrease in funds resulting in closing of a prenatal care site;
2. The health centers received funding reductions resulting in a decrease in services;
3. Hospitals reduced OB clinic sessions due to decrease in the number of hours that residents could work.

The overall critical issue of malpractice and liability for physicians also affected clinics and sparked fear that fewer medical students would choose obstetrics and gynecology as a specialty. Further, all of the providers served women for whom English is a second language; these appointments take longer and some providers had to cut back in order to accommodate for the longer visits.

The survey has been conducted annually, the results of which are located in the chart below. **Franklin County has yet to regain the number of appointments it had in 2003 and continues to hover at 70% capacity.** There are other issues encountered throughout this period: in 2005, two Neighborhood Health Centers closed; in 2006, a slight upswing in appointments can be attributed to two factors. First, Columbus Neighborhood Health Centers, Inc. received funding to expand prenatal care appointment services. Second, City of Columbus Mayor Coleman included funding in the City's budget to allow for re-opening the Westside clinic that Columbus Public Health had closed in 2004. In 2007, the loss is most likely related to clinical provider shortages in community health clinics.





This diminished capacity does explain why the COHMAB has been unable to reduce waiting times for first prenatal care appointments. These studies were instrumental in convening the Prenatal Care Capacity Roundtables to work on addressing prenatal care access and capacity in Franklin County.

Prenatal Care Capacity Roundtables

On October 27, 2004, the COHMAB held the first Prenatal Care Capacity Roundtable with invested community leaders and providers attending, including City Councilwoman Charleta Tavares. The purpose of launching the Roundtable was to heighten awareness and develop solutions to curb the declining prenatal care capacity in Franklin County. In spite of the success of Pregnancy Care Connection in facilitating easier access to prenatal care for pregnant women, waiting times were not decreasing and prenatal care appointments were diminishing.

Subcommittees were established to help define the ongoing work that would be needed to further study the prenatal care capacity issues and take action. The work of these committees is described below. To date, six Roundtables have been held with ongoing work being sustained by the subcommittees.

Prenatal Care Capacity Roundtable Subcommittees

At the initial Roundtable in October 2004, participants identified four feasible areas that impact prenatal care capacity which the community could address: (1) public awareness; (2) the state budget; (3) immigrant and refugee health issues; and (4) the family planning waiver.

Public Awareness Subcommittee

The purpose of the Public Awareness Subcommittee is to increase the overall awareness of the importance of prenatal care and access to care to improve birth outcomes in Franklin County.

When the Public Awareness Roundtable Committee originally formed, there were **three major goals: (1) keep infant mortality on the priority list; (2) educate healthcare professionals and providers about the issue of infant mortality; and (3) increase availability of prenatal care from a risk management perspective.**

The committee dedicated its efforts to re-inform legislators, community leaders and key decision makers of the problem of infant mortality and importance of early prenatal care and the barriers that exist in Franklin County. This group developed a Prenatal Care Capacity fact sheet and presented materials during the 2006 Candidates Forum on Children and Youth hosted by Nationwide Children's Hospital.

The Public Awareness group was also instrumental in supporting community awareness about Centering Pregnancy[®], a model for group prenatal care. The concept of Centering Pregnancy is to bring back a sense of community into prenatal care, and it alters routine prenatal care by bringing women out of exam rooms and into groups for their care.

In the coming year, in addition to educating community leaders about infant mortality, the Public Awareness group has devised a media plan to increase awareness in the general community about the importance of obtaining early and adequate prenatal care.

State Budget and Partnership Subcommittee

The purpose of the State Budget and Partnership subcommittee is to advocate for increased access to early and adequate prenatal care for Ohio's pregnant women. This subcommittee developed a 2007 Advocacy Agenda to push through Ohio's 2008-2009 biennial budget. This agenda included: a) increasing Medicaid coverage for pregnant women up to 200% FPL; b) expanding Medicaid coverage through a waiver to provide healthcare services to women of child-bearing age; c) ensuring Medicaid reimbursement for interpretive services to providers; and d) increasing the State budget Child and Family Health Services line item for local health departments and community organizations to provide health care and enabling services (e.g. outreach, interpretation) for women and children. This legislative campaign included the collaboration and assistance from healthcare professionals, social service providers, and community members living in Franklin County.



The legislature maintained Governor Strickland's proposal to increase Medicaid eligibility for pregnant women from 150 percent of the FPL up to 200 percent FPL. Medicaid for pregnant women includes coverage during their pregnancy and delivery and 60-days postpartum. The Administration estimates that an additional 3,800 Ohio women could be eligible. This expansion has been implemented as of January 1, 2008. Unfortunately, the Child and Family Health Services line item within the Ohio Department of Health suffered a decrease from

FY 06-07 levels. Women's health services are flat funded for the biennium, but Federally Qualified Health Centers received a significant increase.

Immigrant and Refugee Health Issues Subcommittee

The last U.S. census in 2000 revealed that Columbus, Ohio continues to be very diverse. Of the 711,470 documented residents, 6.7 percent of the population was foreign born and 10 percent of the population spoke a language in the home other than English.

The purpose of the Immigrant and Refugee Health Issues Subcommittee is to understand and address the specific needs of pregnant immigrant and refugee women living in Franklin County. Such efforts include raising cultural awareness and providing information on available services to the Somali community and Latino community, including the undocumented population.

As a result of the work of the Immigrant & Refugee Roundtable Committee, a cultural awareness calendar was developed in care of the Ohio Civil Rights Commission; the group collaborated with OSU School of Public Health's Somali women project which is ongoing; members joined the Immigrant & Refugee Women's Health Initiative, a statewide organization to discuss the health needs of this population; and participated in health fairs directly targeted for Latinos and Somalis.

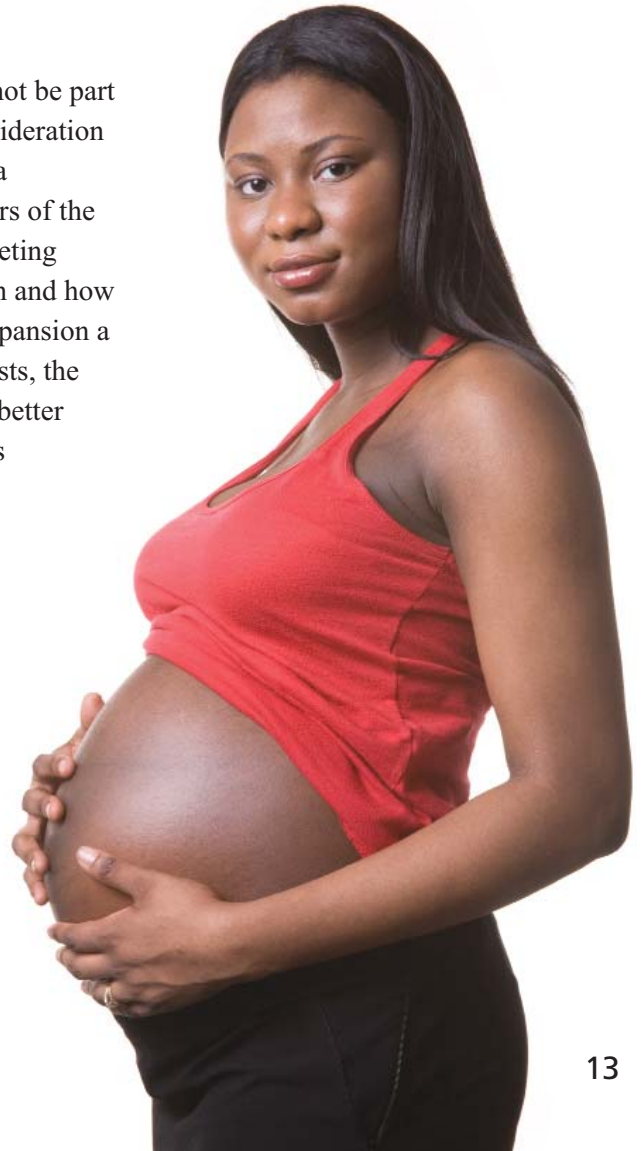
The next major project the group will address is the need for parenting classes in the Latino community. It is the hope of the committee that with the help of the Ohio Hispanic Coalition, there will be an accessible program to the community that previously has not been there. The curriculum used will be the Comenzando Bien materials developed by the March of Dimes. Access to prenatal services in a language that can be understood is one of the key goals; one which there is hope to have a direct impact through this program.

Family Planning Waiver Subcommittee

The approach to improving access to and capacity for prenatal care is broad. Through Perinatal Periods of Risk (PPOR) analyses, it is understood that the best way to reduce fetal and infant mortality in the community is to reduce prematurity and improve the overall health of women. There is currently a national focus for preconception health, based on the premise that all women should be in optimal health prior to conception. An integral component of this care is family planning services. A number of states have family planning services through Medicaid waivers. These waivers extend Medicaid coverage to women, and in some cases men, who are otherwise not eligible. Some states have only income eligibility as the criteria, for example, all women under 200% of poverty. In Ohio, women who become Medicaid eligible as a result of pregnancy lose that coverage 60 days after delivery.

In 2004, the Ohio Department of Health, The Center for Community Solutions and CPH held the first discussion to plan for advocacy in pursuing a Family Planning Waiver for Ohio. The three organizations worked for over a year compiling information, consulting with other states and identifying next steps and other partners. The Center developed a Concept Paper for what a Family Planning Waiver would look like for Ohio.

In 2006, the Concept Paper was submitted to ODJFS. Feedback was that a Family Planning Waiver would not be part of the FY08-09 budget process, but explored for consideration through other avenues. The workgroup continued data gathering and discussions with advocates and members of the Strickland Administration. Plans for 2008 include meeting with the ODJFS Medicaid Director to discuss the plan and how to proceed. State budget constraints will make this expansion a challenge. However, for every 10 cents the State invests, the Federal government will match 90 cents. There is no better match than this. In addition, Family Planning Waivers demonstrate cost savings and contribute to improved birth outcomes also resulting in cost savings.





Barriers to Care Surveys: Providers' Perspective

Beyond the work of the PCC Advisory Committee, the wait time studies, and the Prenatal Care Capacity Roundtables and its subcommittees, the COHMAB explored further why access is challenging for uninsured and underinsured pregnant women with the public OB providers in Franklin County. As stated earlier, public OB providers were surveyed in 2005 to determine the issues behind the decreased capacity. The COHMAB revisited the issues that were highlighted to check on the status of these challenges; if there are new and/or different issues; and if there have been specific actions to address them.

Reduction of Appointments Due to the Cap on Resident Hour Requirements

When the Accreditation Council of Graduate Medical Education implemented a cap on resident hours in July 1, 2003 to an 80 hour work week, providers handled it differently. This only had an impact on hospital-based OB clinics; community and neighborhood clinics do not utilize residents.

Some providers are interested in or have already been able to increase the number of residents to offset the decreased hours. Another hired certified nurse midwives as part of their solution. Still others have just dealt with the change. One hospital-based clinic has yet to recover from this decrease and is unable to achieve the number of patients it had before, from 800 patients per year down to 650 patients.

Because of this decrease, it appears providers have had to become creative in maintaining the number of patients being served; but in the worst case, a 19 percent decrease in patient capacity has an impact on the entire system pressuring women to find care elsewhere. One thing is certain, prenatal appointment capacity building is made more difficult under these circumstances.

Increase in the Number of Immigrant Patients

The make-up of the population in Franklin County continues to grow in numbers and diversity. This is strongly demonstrated in the OB clinics where the number of immigrant women has also increased. Providers have had to learn how to serve a number of culturally diverse women, such as Latina, Somali, West African, Middle Eastern, Russian, and Cambodian.

10% of the population in Franklin County speak a language in the home other than English.

At one clinic, one-third of the prenatal care patients are non-English speaking. Many of the providers surveyed have hired staff that are bi-lingual to assist with patients or encouraged staff to take language and cultural competence classes. Most importantly is access and use of interpretation and translation services in Franklin County. Unfortunately, some providers have struggled with the inconsistencies in levels and practices of interpretation services. Since there are no requirements in Ohio for translators to have specific training or certification, the level of service can vary. Last resort is the use of telephone services as interpreters; all of the providers agreed that this type of service is the least desirable, but is used when necessary.

Among the issues facing providers that serve these women, is the number of secondary issues that these women bring with them such as health problems including dental and depression, transportation problems, minors without parents in the country, low education, and domestic abuse. These issues, coupled with language and cultural barriers, create longer appointments and a decrease in the overall number of women that can be served.

Providers have developed and implemented different strategies to deal with immigrant populations. Some have designated times for specific languages such as Spanish only or Somali only appointments. This allows for providers to have allotted times for interpreters to be available and clinics hours to run smoothly and timely. Other providers have established the Centering Pregnancy® program within their clinics. This is an evidence-based program where pregnant women of similar due dates are part of a group setting. Each woman still maintains a private evaluation with a clinician, but the group discusses various important topics related to pregnancy and delivery. Clinic providers like the Centering Pregnancy® program because it maximizes resources and is cost effective.



Medical Malpractice and Liability Issues

Physicians across the country, including Ohio physicians, are experiencing significant increases in their liability insurance, especially OB/GYNs. According to a July 16, 2004 news release by The American College of Obstetricians and Gynecologists (ACOG), Ohio was identified as one of 23 “red alert” states with a medical liability insurance crisis: “When OB/GYNs can’t find or afford medical liability insurance, they are forced to stop delivering babies, curtail surgical services, or close their doors. Across America, pregnant women cannot get the prenatal and delivery care they need but ACOG warns that the liability crisis hurts all women.” The concern is that this would not only have an impact on current OB/GYNs, but also the future of obstetrics and the potential decrease in the number of medical students choosing obstetrics as a specialty. This would have a significant impact on access to prenatal care services.

“When OB/GYNs can’t find or afford medical liability insurance, they are forced to stop delivering babies, curtail surgical services, or close their doors. Across America, pregnant women cannot get the prenatal and delivery care they need but ACOG warns that the liability crisis hurts all women.”

Among the providers surveyed, the physicians on staff had contracted directly with hospitals where often insurance is then covered by the hospital system. It seems that physicians are folding private practices and joining hospital-based systems in order to continue practicing. The burden then falls on hospitals to pay for liability coverage. It is questionable how long hospitals can maintain that cost.

The Ohio General Assembly did take on this issue and passed Amended Substitute Senate Bill 281 (124th GA) in 2002, which imposed caps on compensatory damages that may be awarded as a result of a medical lawsuit. However, according to a March 23, 2008 Associated Press article, Ohio had fewer OB/GYNs in 2007 than it did in 2002, a 5 percent decrease over five years. Meanwhile, the number of physicians increased over the same time period from 28,000 to 30,000. The article further suggests that rising medical costs and increasing technology may be playing a role in decreased OB/GYNs. So, although the providers surveyed had not experienced a problem with maintaining OBs, this could still be an issue in the long-term. This will be important to monitor especially as the number of initial prenatal care appointments has been decreasing.

Other Barriers Confronted

In surveying the public OB providers, they revealed a number of other barriers to providing prenatal care to women:

- A number of providers indicated that the Medicaid Managed Care plans make it difficult to provide needed services because of preauthorization and limited drug formularies.
- Increasing the number of providers for Medicaid populations would be difficult if provider rates are not increased.
- Leaders of healthcare systems are more business focused and driven by profit. This philosophy often puts healthcare providers at odds.
- The populations served transfer more often from clinic to clinic resulting in fragmented care and is also time and resource consuming.
- Clinic hours are not accessible for working population.
- The number of patients expected to be seen in a day.
- Illiteracy of patients creates challenges; they do not understand their Medicaid plans, are not able to accurately fill out health information documents, and are not able to read important health material.

Conclusion/Next Steps

There are a number of reasons that impede providers from increasing prenatal care services for more women. Unfortunately, as the number of initial prenatal care appointments decrease, the number of women needing access to prenatal care for low-income populations is increasing. There are some solutions that appear to be of some success such as the Centering Pregnancy® program, but for the most part, many of these issues do not currently have solutions and will require creativity, commitment, and funding to handle the increased complex obstacles.

The prenatal care capacity crisis must be addressed by community, state, and national leaders who can increase availability of prenatal care for uninsured and Medicaid eligible women. These actions will require increased funding for clinics along with increased number of OB/GYNs to provide public prenatal care.

Appendix

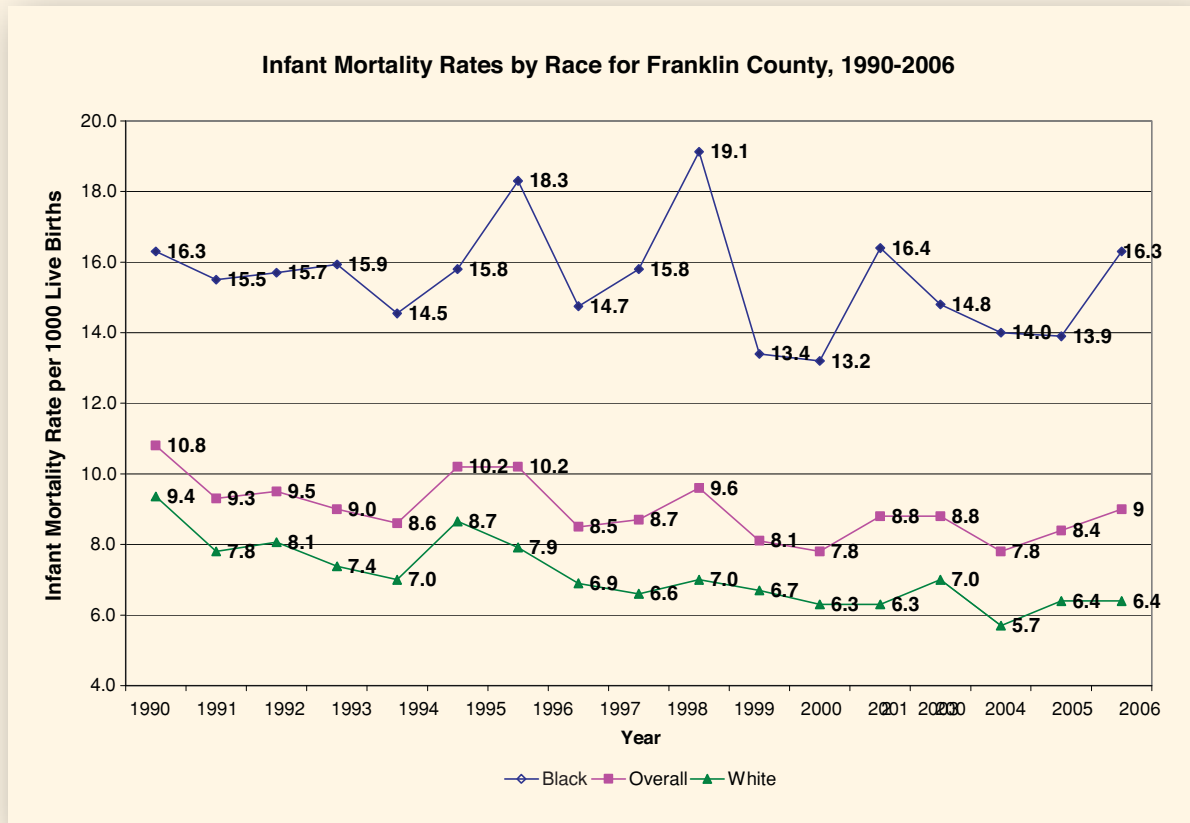
Franklin County Vital Statistics Data



Following are graphs of key data that inform and drive our work. Data was obtained from the Ohio Department of Health Data Warehouse and Vital Statistics files. Data was analyzed and graphs prepared by Columbus Public Health.

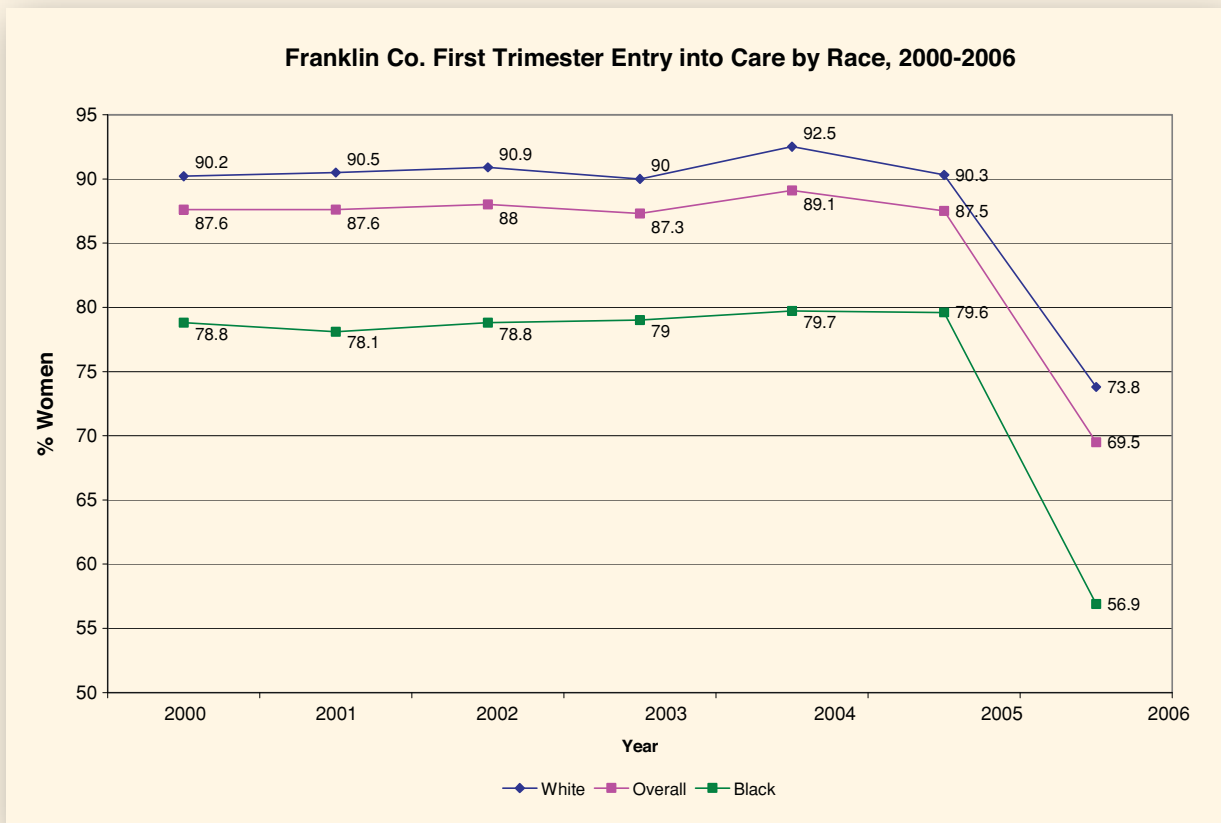
Infant Mortality Rates

The Infant Mortality Rate (IMR) is the most sensitive index of a community's health. Franklin County's rates indicate that first there is unacceptable persistent disparity between Black and White populations. Secondly, no demographic in Franklin County has achieved the National Year 2010 Goal of 4.5 deaths per 1000 live births. Finally, the past two years show overall increases in deaths.



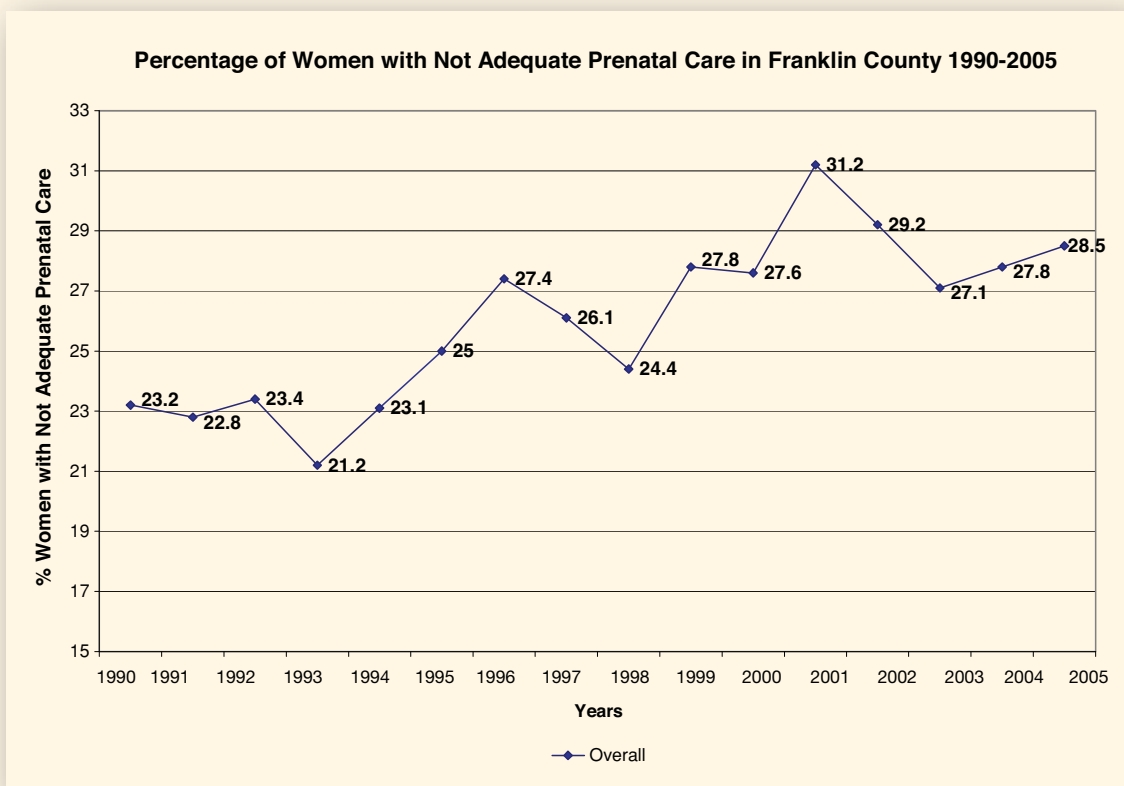
Percentage of Women Entering Care in the First Trimester

Early, first trimester, entry into prenatal care (PNC) is considered very important for improving birth outcomes. First trimester screening and testing are critical in identifying and intervening early to address problems. The Year 2010 Goal is 90% of women will obtain prenatal care in the first trimester. Prior to 2006, only White women had achieved this goal in Franklin County. Women of color and women without private health insurance are less likely to enter prenatal care during the first trimester. However, beginning in 2006, there was a sharp decline for first trimester entry into care. Prior to 2006, information for the birth certificate was gathered directly from new mothers. Information collected regarding when a mother began prenatal care was based on the mother's recall. Starting in 2006, entry into care (and other information required for the birth certificate) was taken from medical records. Basically, statistics prior to 2006 reflect inaccurate and inflated rates of first trimester entry into care.



Percentage of Women with Inadequate Prenatal Care

Using the Kotelchuck Index, Columbus Public Health analyzed whether women had Adequate or Inadequate prenatal care. This Index takes into account timing of entry into care, the number of visits, and gestational age at birth. What is concerning about the data is that there is an overall increasing trend in the percentage of women with inadequate prenatal care in Franklin County.



Acknowledgements

On behalf of the Council on Healthy Mothers and Babies, we would like to thank the following individuals or organizations for their contribution to the work on building Prenatal Care Capacity and with Pregnancy Care Connection. This work could not have been possible without their dedication and commitment.

Columbus Public Health for your contribution to this report and your continued partnership especially, Carolyn Slack, Karen Gray and Grace Kolliesuah.

Pregnancy Care Connection Providers

Columbus Public Health – Women’s Health Centers East, West, North
Columbus Northeast Health Center
Doctors Hospital
East Central Health Center
Grant Medical Center
Hilltop Health Center
John Maloney Health Center
Mount Carmel St. Ann’s
Mount Carmel West
OhioHealth Wellness on Wheels
The Ohio State University Medical Center
OSU Family Practice at University Hospital East
OSU Thomas E. Rardin Family Practice Center
Riverside Methodist Hospital
St. Stephen’s Health Center

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